County of San Diego
Health and Human Services Agency
Mental Health Services

Organizational Provider Operations Handbook

Child/Adolescent Mental Health Services

for County Owned & Operated and Contracted Programs

Note:
The contract, including the Pro Forma and the Statement of Work takes precedence over this Organizational Provider Manual.
If providers find any elements of the contract to be in conflict with this manual, please contact QI staff via email at tess.widmayer@sdcounty.ca.gov)
and we will work with BHS Administration to resolve the matter.

[Appendix to Mental Health Plan]

Complete Revision July 2011

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TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

LIST OF APPENDICES

TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

ABBREVIATIONS REFERENCE GUIDE

ACL – Access and Crisis Line
AMHS – Adult Mental Health Services
A/OAMHS – Adult/Older Adult Mental Health Services
ASP – Augmented Services Program
ASW – Associate Social Worker (registered with the BBS)
BBS – Board of Behavioral Sciences
B&C – Board and Care
CA-QOL – California Quality of Life (client survey)
CMUMC – Case Management Utilization Management Committee
CCHEA – Consumer Center for Health Education and Advocacy
CCISC – Comprehensive, Continuous Integrated System of Care
CCR – California Code of Regulations
CCRT – Cultural Competence Resource Team
CFR – Code of Federal Regulations
CMHS – Children's Mental Health Services
CMS – County Medical Services
COTR – Contracting Officer's Technical Representative
CSS – Community Services and Support
DCS – Deaf Community Services
DHS – Department of Health Services (State of California)
DMH – Department of Mental Health (State of California)
DSM-IV-TR – Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision
ECR – Error Correction Reports
EPU – Emergency Psychiatric Unit
FFP – Federal Financial Participation
FFS – Fee-For-Service
FSP - Full Service Partnerships
FTE – Full-Time Equivalent
HHSA – Health and Human Services Agency
HIPAA – Health Insurance Portability and Accountability Act
HMO – Health Maintenance Organization
ICM – Intensive Case Management
IMF – Intern Marriage and Family Therapist (registered with the BBS)
IMD – Institute of Mental Disease
LCSW – Licensed Clinical Social Worker
LPS – Lanterman-Petris-Short (Conservatorship)
McFloop – Multi-Use Complete Feedback Loop
MFT – Marriage and Family Therapist
MHP – Mental Health Plan
MHS – Mental Health Services
MHSA – Mental Health Services Act

MHSIP – Mental Health Statistics Improvement Program
MIS – Management Information Systems
MSR – Monthly Status Report
NOA-A – Notice of Action – Assessment
NOA –B – Notice of Action
OIG – Office of Inspector General
OP – Outpatient
Optum - OptumHealth
P&T – Pharmacy and Therapeutics Standards and Oversight Committee
PEI - Prevention and Early Intervention
PCR – Program Contract Representative (Program Monitor)
PSR – Psychosocial Rehabilitation
QI – Quality Improvement
QM – Quality Management
QRC – Quality Review Council
SMA – Statewide Maximum Allowances
SDCMHA – San Diego County Mental Health Administration
SDCPH – San Diego County Psychiatric Hospital
SF/LTC – Secure Facility/Long-Term Care
SNF/STP – Skilled Nursing Facility/Special Treatment Program
SOC – Systems of Care
TAR – Treatment Authorization Request
TBS – Therapeutic Behavioral Services
TBI – Traumatic Brain Injuries
UBH – United Behavioral Health
UM – Utilization Management
UMDAP – Uniform Method for Determining Ability to Pay
UR – Utilization Review
URC – Utilization Review Committee
USD – University of San Diego (Patient Advocacy Program)
W&IC – Welfare & Institutions Code (State of California)
WET - Work Force Education and Training

TABLE OF CONTENTS

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Customer Service

San Diego County Behavioral Health Services (SDCBHS) recognizes that its greatest strength lies in the talent of its providers and expects them to always treat clients, families and other consumers with respect, dignity and courtesy. They should be treated *without* regard to race, religion, creed, color, gender, economic status, sexual orientation, age, source of payment or any other non-treatment or non-service related characteristic.

Clients and families expect high-quality customer service and they deserve it. They want fast, efficient service and caring, professional treatment. Exceptional customer service includes:

- Treating customers with courtesy, respect, professionalism and a positive attitude
- Responding to customers in a timely manner whether in person, by phone, in writing or via e-mail
- Being aware of cultural diversity and focusing on understanding customer differences
- Providing complete, accurate and reliable information and feedback

County and contracted organizational providers are expected to ensure that they have a customer-first attitude which is instilled throughout their operations. Systems should be in place so that customers are able to voice their problems or complaints anonymously. Input should be listened to and acted upon. Programs can then use the input to look at systems and improve them. The methods your program or legal entity uses may be through informal conversations or more formal methods such as individual interviews, focus groups, surveys, and suggestion/comment cards or forms.

The recommended way to get ongoing feedback from customers is to have suggestion or comment cards available to them on site. The advantage of using brief surveys and comment cards is that they are more user friendly and convenient. That way you can receive timely input on many aspects of your services that can be reviewed and acted upon quickly. A critical element of using suggestion or comment cards is to ensure that individual's identities are held confidential so that they will feel safe to comment or respond to surveys candidly without fear of any recrimination or retaliation.

The following are the basic expectation that SDCBHS has for all County and Contracted programs:

1. Establish Customer Service Standards which may include elements such as:
    - Answering phones and email in a friendly and timely manner
    - Informing clients when appointments will be cancelled

- Having a positive attitude to clients and families.
- Going the extra mile for clients, such as fitting in one more client when you are about to close, taking more time to explain a bill to a confused client, initiating a friendly conversation, dealing with questions instead of deflecting them to others.
- Having a clean, neat, organized and cheerful workplace can never be undervalued. A welcoming waiting room invites visitors to feel at home and creates an expectation that services will be equally caring and accepting.

2. Ensure that all staff members are aware of the standards and are clear that adhering to Customer Service Standards is an expectation of your organization and your facility.

3. Encourage your customers to give you input that will allow you to make changes to improve the service that you are delivering.

4. Ensure clients and families that if they give input to you or your program about improvements that are needed that they will not face any kind of retaliation.

5. Enhance your program based on the input you receive from customers to demonstrate that you are listening.

6. Make Customer Service training available to all staff.

7. Recognize great customer service

SYSTEMS OF CARE

A. SYSTEMS OF CARE (SOC)

Mission of Health and Human Services Agency (HHSA) Mental Health Services (MHS)

The mission of the Health and Human Services Agency is: "Through partnerships, and emphasizing prevention, assure a healthier community and access to needed services, while promoting self-reliance and personal responsibility." Mental Health Services adds to that mission: "To provide quality, cost effective mental health treatment, care, and prevention services by dedicated and caring staff to people in the service population."

Client Population served by the Mental Health Plan (MHP)

Clients who are seriously emotionally disturbed (SED), as defined below, and who are:

- Youth up to age 18 (EPSDT services up to age 21),
- Clients with co-occurring mental health and substance use,
- Medi-Cal eligible and meet medical necessity,
- Indigent, and/or
- Low income/underinsured.

Seriously Emotionally Disturbed (SED) Clients:
The priority population for Children's Mental Health Services, including clients seen under MHSA, are seriously emotionally disturbed (SED) children and youth. SED clients must meet the criteria for medical necessity and further are defined as follows (per California Welfare & Institutions Code Section 5600.3):

Seriously emotionally disturbed children or adolescents means minors under the age of 18 years who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of the following criteria:

(A) As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:

(i) The child is at risk of removal from home or has already been removed from the home.

(ii) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.

(B) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

(C) The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

System of Care Principles

Children's Mental Health Services (CMHS) programs, regardless of funding source, serve a broad and diverse population of children, adolescents, transitional youth and families throughout San Diego County. An array of services are provided through Organizational Providers, Fee For Service Providers, and Juvenile Forensic Providers. CMHS San Diego is a "System of Care" County. The System of Care is based on Child and Adolescent Service System Program (CASSP) System of Care principles and the Wraparound Initiative of the State of California (All County Information Notice 1/28/99, April 17, 1999; and SB163, Wraparound Pilot Project). System of Care Principles (May 2005) shall be demonstrated by ongoing client/parent participation and influence in the development of the program's policy, program design, and practice evidenced by:

- Individualized services that are responsive to the diverse populations served
- Cultural competence and sensitivity
- Client-focused, family-centered services
- Outcome driven services
- Collaboration of families/youth, public agencies, private organizations and education
- Community-based approach that provides maximum linkage and integration to the local community resources
- Multi-disciplinary and strength-based approach

Providers, Medi-cal and Non Medi-Cal shall plan and deliver services in a manner consistent with the Children's Mental Health System of Care philosophy and principles. Services shall be community-based and emphasize the strengths of the client and family.

Providers shall demonstrate family partnership in the development and provision of service delivery. Providers shall also demonstrate organizational advancement of family partnership in the areas of program design, development, policies and procedures, etc.

All facilities shall comply with the requirements of the Americans with Disabilities Act (ADA) and California Title 24.

Measuring outcomes is an integral aspect of System of Care principles. Standard outcomes have been established for all CMHS providers. *Specialized programs may have individual program*

outcomes either in addition to or in lieu of standard outcomes measured by all programs. These system goals are tracked and reported as system wide outcomes in an annual report.

Goals

Programs shall provide developmentally appropriate clinical services described herein to accomplish the following goals:

- Maintain client safely in their school and home environment
- Reduce recidivism related to criminal habits and activities
- Increase school attendance and performance resulting in a higher rate of successful completion of their educational program (with high school diploma or equivalent)
- Improve client's mental health functioning at home, school, and in the community
- Increase the individuality and flexibility of services to help achieve the client and family's goals
- Increase the level and effectiveness of interagency coordination of services
- Increase the empowerment of families to assume a high level of decision-making in all aspects of planning, delivering, and evaluation of services and supports

Outcome Objectives

All treatment providers shall achieve the outcome objectives as found in the Data Requirements section of this handbook.

Services for Dual Diagnosis (Mental Illness and Co-occurring Substance Use Disorders)

San Diego County Adult/Older Adult Mental Health, Children's Mental Health Services and Alcohol and Drug Services, (Behavioral Health Services) recognizes that clients with a dual diagnosis, a combination of mental illness and substance use disorders, may appear in all parts of the system. These conditions are associated with poorer outcomes and higher cost of care. Integrated treatment of co-occurring substance use and mental health diagnosis is recognized evidence-based practice.

CMH has adopted the Comprehensive, Continuous, Integrated System of Care (CCISC) model that espouses a treatment and recovery philosophy that promotes the integrated treatment of clients with mental illness and substance use issues. Individuals who meet mental health treatment eligibility criteria and who also have a secondary diagnosis of substance use shall receive treatment focused on the mental health diagnosis and the impact of the substance use issue. Upon intake to a mental health program, the presence of substance use by clients shall be

assessed. During treatment, substance use is reassessed on an ongoing basis and discussed with the client in terms of its impact on and relationship to the primary mental health disorder. Client Plans shall clearly reflect any services that may be needed to address the co-occurring substance use problems. Progress notes shall meet all Medi-Cal and Title 9 documentation requirements and must list a mental health diagnosis or problem as the focus of the intervention. Exceptions exist for clients who are dually diagnosed in EPSDT programs.

To support the implementation of the Dual Diagnosis Initiative, Mental Health Services recommends the development of Dual Diagnosis Capable programs. Programs participating in the CCISC Initiative shall demonstrate the following to be considered dually capable:

- San Diego Charter adoption and implementation
- Co-morbidity Program Audit and Self-Survey for Behavioral Health Services (COMPASS) completion
- Action Plan development
- Program Policies:
    - Welcoming Policy/Statement
    - MHS Co-occurring Disorders Policy
    - Other
- Training and supervision of staff in Integrated Treatment Practice Model
    - Integrated Screening
    - Integrated Clinical Assessment
    - Integrated Psychiatric Assessment
    - Implementing Stage of Change Interventions
    - Measure of client progress as evidence in the client plan and in progress notes (Outcomes: stage of change level, number of relapses, reduction of alcohol/drug use by type, number of months clean and sober, other)
- QI Baseline Monitoring Tool compliance

Dually enhanced services differ from dually capable services by the intensity of services provided and severity of mental illness and substance abuse of the client. Dually enhanced services are provided to "Quadrant Four" individuals, who are the clients with the most serious and persistent mental illness and substance dependence.

Dually enhanced programs must meet the following criteria:
Dual Capable criteria plus:

Advanced staff and supervision competencies:

- Some direct service staff have certification in motivational therapy
- Some direct service staff are certified as an Alcohol and Drug Counselor

Specialized Programming such as

- Intensive case management services

- Dual Inpatient Unit
- Dual Residential Program
- Array of supported housing for dual diagnosed clients that include:
    - Dry/Damp/Wet Housing
    - Supported Sober Living

For additional information on the Dual Diagnosis initiative, please refer to the County of San Diego Health and Human Services Agency, Adult/Older Adult Mental Health, Children's Mental Health Services, Alcohol and Drug Services Charter and Consensus Document for Co-occurring Psychiatric and Substance Abuse Disorders, March 2003; and the County of San Diego, Mental Health Services Policy and Procedures Specialty Mental Health Services for Clients with Co-occurring Substance Use Problems No. 01-06-117, February, 2004, and the HHSA, Dual Diagnosis Strategic Plan, 2002.

Services to Youth in Transition

In recent years, the existence of a significant mental health service gap for youths 18-24 transitioning from the Children's Mental Health (CMH) System of Care to the Adult Mental Health (AMH) System of Care has been identified. To address this issue, the County of San Diego, HHSA MHS has implemented the Youth Transition Services Plan. This plan identifies transitional youths' needs and existent resources, addresses services gaps, and makes recommendations to the AMH and CMH Systems of Care. This transition plan is the blueprint for the improvement of youth transition services within the mental health system.

The mission of the Youth Transition Services Plan is for CMH and AMH Systems of Care to work in partnership with youths to develop and implement services that are developmentally and culturally appropriate. To accomplish this mission, both systems are working together to address the unique needs of youths and to integrate a seamless referral process. Procedures have been developed to support the implementation of this process. The Youth Transition Self-Evaluation begins the process for identifying the mental health needs of transitional age youths and ensuring that comprehensive services are available to youths transitioning from the CMH system to the AMH system.

Adult and children's mental health providers shall coordinate with each other and seek appropriate consultation to ensure that the unique needs of this population are met. An ongoing workgroup shall work to address issues regarding services and coordinate the varied agencies that provide services for this population. This group developed the Transitional Youth Resource Directory to ensure that those working with this population have accurate information on available services for these youths.

For additional information on the Youth Transition Services Plan, please refer to the County of San Diego, HHSA MHS, Mental Health Youth Transition Services Plan, July 2000. You may

also obtain further information by referring to the policies required for county-owned and -operated programs: County of San Diego, HHSA MHS Transitional Age Youth Referral Policy (No. 01-01-114) and County of San Diego, HHSA, MHS Youth Transition Self-Evaluation Policy (No: 06-01-113).

B. COMPLIANCE AND CONFIDENTIALITY

The County of San Diego Health and Human Services Agency (HHSA) is committed to maintaining a culture that promotes the prevention, detection and resolution of instances of conduct that do not conform to laws, rules, regulations, or County policies or procedures.

County Compliance Programs

As part of this commitment, all County Mental Health Services employees are expected to be familiar with and adhere to the HHSA Compliance Program that includes all of the required elements of a compliance program as stated below. In addition, County Programs must have processes in place to ensure that they are adhering to all requirements in the HHSA Code of Conduct and Statement of Incompatible Activities, including but not limited to the Compliance Standards listed below.

For more information:

HHSA Code of Conduct and Statement of Incompatible Activities:
http://hhsa_intranet.co.san-diego.ca.us/policy/mpp/m/m1_2.pdf

HHSA Compliance Program:
http://hhsa_intranet.co.san-diego.ca.us/policy/index.html

Provider Compliance Program

Each provider entity is required to have an internal compliance program to ensure that all applicable state and federal laws are followed. At all times during the terms of their contracts, providers shall maintain and operate a compliance program that meets the minimum requirements for program integrity as set forth in 42 CFR 438.608. Failure to establish and maintain a compliance program as required by this section shall be considered a material breach of contract.

Elements of a compliance program

1. Code of Conduct and Compliance Standards, as described below.
2. Compliance Officer, who is a senior manager charged with responsibility for overseeing and monitoring implementation of the compliance program.
3. Communications, which create avenues for employees to raise complaints and concerns about compliance issues, including billing fraud, without fear of retribution.
4. Training and Education for employees regarding compliance requirements.

5. Auditing and Monitoring Systems, designed to reasonably detect and prevent potential violations of laws and regulations relating to health care and human services funding and programs.
6. Enforcement and Disciplinary Actions, within labor guidelines, to enforce the program including discipline of individuals for engaging in wrongful conduct or for failing to detect or report noncompliance.
7. Response and Prevention, which consists of mechanisms to respond to and investigate all reasonable concerns regarding compliance and suspected noncompliance and of taking necessary corrective action to prevent recurrence.

Code of Conduct

A Code of Conduct is a statement signed by all employees, contractors, and agents of an organization that promotes a commitment to compliance and is reasonably capable of reducing the prospect of wrongful conduct. Codes of Conduct should be created at the agency level.

Compliance Standards

All programs, both County and contracted, shall have processes in place to ensure at the least the following standards:

- Staff shall have proper credentials, appropriate experience and expertise when providing client treatment and services in the area in which they function.
- Staff shall accurately and completely document all client encounters in appropriate records in accordance with funding source requirements and County guidelines.
- Staff shall participate in activities that promote quality assurance and quality improvement and bring concerns regarding possible deficiencies or errors in the quality of care, treatment or services provided to clients to the attention of those who can properly assess and resolve the concern.
- Staff shall take reasonable precautions to ensure that billing and/or coding of client services are prepared and submitted accurately, timely, and in compliance with all applicable federal, State, local laws, rules and regulations and HHSA's policies and procedures.
- Staff shall provide that no false, inaccurate or fictitious claims for payment or other reimbursement are submitted, by billing only for eligible services actually rendered and fully documented. When coding for services, only service codes that accurately describe the services provided will be used.
- Staff shall act promptly to report and correct problems if errors in claims or billings are discovered.

MHP's Compliance Hotline

The MHP has created a Hotline for its own staff as well as Contractors to report concerns about a variety of ethical, legal, and billing issues. The confidential Hotline is toll-free and available 24 hours per day, 7 days per week. Callers may remain anonymous if they wish. The number of the Compliance Hotline is 866-549-0004.

Documentation Requirements

All organizational providers are recipients of Federal funds and as such are required to prepare and maintain appropriate medical records on all clients receiving services in compliance with Title 9, Chapter 11 and 42 CFR guidelines. The provider is expected to meet all documentation requirements established by the MHP in the preparation of these medical records. This includes all providers of outpatient, day treatment, and case management services. The MHP has the responsibility to prepare and maintain the Documentation and Uniform Clinical Record Manual (DUCRM), which outlines the MHP's requirements and standards in this area. The Quality Improvement Unit distributes copies of the MHP's most recent version of the DUCRM annually throughout the organizational provider system. A copy may also be obtained at anytime by contacting the County QI Unit (619) 584-5026 or County Medical Records (619) 692-5700, extension 3. The Management Information System Anasazi User Manual contains the detailed and specific requirement for the most commonly used services. This information is made available at www.optumhealthsandiego.com or can be found in Management Information Systems Anasazi User manual Organizational Provider Operators Handbook Volume II.

Many of the requirements present in the MHP's DUCRM are derived from the contract to provide specialty mental health services between the California Department of Mental Health and San Diego County Health and Human Services, Exhibit A, Attachment 1, Appendix C "Documentation Standards for Client Records". Other documentation requirements have been established by the MHP's Uniform Medical Record Committee, which is an ad hoc committee chaired by the Quality Improvement Unit.

In order to ensure that organizational providers are knowledgeable of documentation requirements, the Quality Improvement Unit provides the following on an ongoing basis:

- Annual in-service training for all provider program managers that reviews the most current edition of the DUCRM, highlighting modifications or additions to the manual;
- Quarterly in-service documentation trainings for all new clinical staff, or any clinical staff that may need a documentation review;
- In-service trainings that are provided on-site at program's request, tailored to program's specific documentation training needs; and

- In-service trainings provided on-site at a program when QI has identified a specific documentation training need.

Compliance in documentation requirements by all organizational and county providers is monitored on an annual basis via medical record reviews. A Quality Improvement Specialist performs the medical record reviews. The Quality Improvement Unit has the responsibility to track and monitor results of these medical record reviews, and may require a provider to develop a Plan of Correction to address specific documentation requirements that are found to be out of compliance.

For more information about the San Diego County Compliance Office contact:

http://www.sdcounty.ca.gov/hhsa/programs/sd/compliance_office/privacy_and_security_information_notices.html

CONFIDENTIALITY

Providers and their agents will abide by applicable state and federal laws regarding confidentiality. Applicable law could include, but is not be limited to, 45 CFR 164 (HIPAA), CA Civil Code 56 (CMIA), 5 U.S.C. § 552a (the 1974 Privacy Act), U.S.C 38 §7332 (Veterans Benefits), CA W&I Code 10850.1 (Multiple Disciplinary Teams). The maintenance of client confidentiality is of primary importance, not only to meet legal mandates, but also because of the fundamental trust inherent in the services provided through the MHP.

MHP Responsibilities

In order to ensure compliance with confidentiality policies and protocols, the MHP enforces the following procedures:

- Every member of the workforce* is informed about confidentiality policies, as well as applicable state and federal laws regarding client anonymity and the confidentiality of clinical information.
- As a condition of employment, each member of the workforce signs a confidentiality agreement, promising to comply with all confidentiality protocols.
- Any client treatment records gathered during the course of provision of services, provider site and record reviews, or as necessary, are protected through strictly limited access. Internal clinical staff has access to case data and files only as necessary to perform their jobs.

**Workforce is defined as employees, volunteers, trainees, and other persons whose conduct, in the performance of work for the provider, is under direct control of the provider, whether or not the individual is paid by the provider.*

COMPLIANCE AND CONFIDENTIALITY

Provider Responsibilities

Each provider will act in accordance with good judgment, clinical and ethical standards and State and Federal law to ensure that all written and verbal communication regarding each client's treatment and clinical history is kept strictly confidential.

Every provider must have policies, procedures and systems in place to protect the confidentiality (or security) of health information and individual rights to privacy. Requirements include safeguards to prevent intentional or accidental misuse of protected health information and sanctions for employee violations of those requirements.

Each provider must train all members of its workforce on the policies and procedures with respect to protected health information. The provider must document that the training on confidentiality has been provided. At a minimum, documentation of training shall consist of a signed acknowledgement by the member of the workforce specifying which training has been received and the date the training was taken. The provider must retain the documentation of the training for six years. These training records will assist the provider in identifying where supplementary training needs to be conducted, if there are changes in the privacy or security regulations.

Every provider must have in place a Confidentiality Agreement for all workforce members. The Confidentiality Agreement should sufficiently identify the type of information to be protected, the worker's /vendor's responsibility to protect it, and methods that must be used to protect it in order to assure confidentiality and to comply with Health Insurance Portability and Accountability Act (HIPAA) regulations. The Agreement must include a signed statement from the workforce member/vendor saying that he or she has received the information related to the maintenance, disclosure, or destruction of confidential information. This statement must be signed within a reasonable period of time after the person joins the provider's workforce. Additionally providers must be able to also access documentation showing that all vendors and business partner personnel with access to protected information have also signed such agreements with their employers.

Contractor and its agents and employees are subject to and shall comply with the Child Abuse Reporting Law (California Penal Code section 11164) and Adult Abuse Reporting Law (California Welfare and Institutions Code section 15630).

Providers must provide a written notice of information practices –"Notice of Privacy Practice"—to all clients. Additionally, providers are to distribute the County Mental Health Plan (MHP) Notice of Privacy Practice to all new clients. A notation is made on the Assessment form (MHS-650 and/or MHS-663 and/or MHS 680) when the MHP-Health Plan NPP has been offered.

Providers should disclose to clients the fact that records may be reviewed in the course of supervision, case conferences, and quality management.

For further information regarding legal and ethical reporting mandates, please contact your agency's attorney, the State licensing board or your professional association.

Handling/Transporting Medical Record Documents Outside Certified Clinics

To maintain the confidentiality of all client and family members and to maintain security of all medical records, all Mental Health Programs (County and contract) will transport medical records in accordance with a set of guidelines. Medical records must be maintained at a certified clinic site or an approved school site. When a medical document is completed at another service site, the document must be transported to the main program site as soon as possible but no later than 5 working days. The standard protocol for storing confidential materials shall be maintained until transport is possible, i.e. records kept in a locked cabinet.

When transport of the entire medical record is necessary, the following procedures shall be implemented:

- The entire medical record must be returned to the clinic or satellite the same day. No staff can keep the entire medical record overnight at a personal residence;
- The program director shall designate staff members who will be authorized to transport any medical records;
- The staff member shall inform the program director or designee when transport of a medical record is necessary;
- The medical record must be signed out and signed in by staff that will be transporting the record;
- Medical records shall be transported in a secured or locked portable file box or personal briefcase;
- While transporting, the records shall be secured in the vehicle;
- The staff person shall maintain the locked container with the medical records at all times until the transfer is completed;
- Under no circumstances are any records to be left unattended.

The staff person transporting the records is responsible for maintaining security and confidentiality of medical records at all times.

COMPLIANCE AND CONFIDENTIALITY

When transporting Identifying Client Data or Medical Record Forms such as progress notes or forms requiring signatures, no identifying information shall be put on these documents until which time said documents are secures in the client's medical record at the primary clinic where the record is being stored. Progress notes or other individual documents transported while in the field shall not contain the full name of the client. Only the initials of the client's name or the client's case number will be put at the bottom of the form. When transferring the document into the medical record at the primary clinic site, the full name and case number of the client will be written on each page within three (3) working days.

A staff member may carry identifying client information only under the following limited circumstances.

1) The staff member is transporting medical records originated at another service site to the main program site where the record is housed (see paragraph 2 of this section).

2) The staff member is doing work outside the clinic site and must carry some client-identifying data from which to contact individuals/families while off site.

The staff member carrying identifying client data will ensure the maintenance of confidentiality by following these guidelines:

1) The confidential information will be with the staff member at all times. It will not be left unattended at any time or place. **This also refers to laptops which may contain client information.** Client information may be kept on an external drive (thumb drive) if appropriately secured.

2) Any client information, including telephone number, address or case number should not be linked to the fact that they are receiving mental health services.

3) The information will not at any time be left overnight in the car or car trunk of the staff member. It will be maintained in a secure container and taken with the staff member at all times.

4) Ideally, the information is kept in a locked compartment, such as a locked briefcase or boxed file. If this is not possible, the information is to be stored in a secure holder such as a three ring binder or accordion file which would not allow the information to be dropped. A manila folder is not adequate. All compartments or containers must be pre-approved for use by the program director.

In the event of a loss of a portion of a medical record or the MR, an incident report should be completed and sent to program monitor. Client, parent, or legally responsible adult shall be notified.

Privacy Breaches of Confidentiality

There are new state laws and regulations that went into effect January 1, 2009 regarding confidentiality breaches. Programs are required to familiar with these new laws. In summary, SB541 adds or changes information on what to do if there are confidentiality breaches, including prompt reporting of privacy to CDPH, notification to patient no later than 5 days after the breach has been detected by the facility, and increased fines and penalties for privacy breaches. SB541 requires reporting of any "unlawful or unauthorized assess" to PHI. "Unauthorized" means "*the inappropriate access, review, or viewing of patient medical information without a direct need for medical diagnosis, treatment, or other lawful use as permitted by law*".

In addition, under new federal regulations effective 9/17/09, Health Information Technology for Economic and Clinical Health Act (HITECH) will require notification to patients "without reasonable delay" but no later that 60 days after discovery, unless asked by law enforcement due to ongoing investigation. For larger breaches, see reporting requirements in addition to following all State and Federal laws and regulations, providers shall report to SDCMHS through the Serious Incident reporting process.

Privacy breaches commonly occur in the following ways:

1) Confidential materials being disposed of in non-secured trash receptacle
2) PHI left out on desks and computer screens
3) Laptops stolen when transported back and forth from work to home
4) Chart and other PHI carried outside the facility, then lost or stolen
5) Unlawful or unauthorized access to PHI (peeking issues)
6) Inappropriate verbal disclosures in and out of the workplace.

Claiming and Reimbursement of Mental Health Services

When providing reimbursable mental health services, providers are required to utilize all available payor sources appropriate for reimbursement of services. Many clients have one or more insurance sources (e.g., Medicare, indemnity, PPO, HMOs, Medi-Cal) and it is the responsibility each program to appropriately bill and collect reimbursement from primary and secondary insurance sources. For all clients receiving mental health services, programs are required to be aware of all available payor sources, be able to verify eligibility and covered benefits, obtain an Assignment of Benefits (AOB), track and process Explanation of Benefits (EOBs) and primary insurance denials, in order to seek reimbursement from secondary payor sources. All billing and submission of claims for reimbursement must be in accordance with all applicable County, State and Federal regulations.

For detailed guidelines and procedures regarding insurance billing, claims processing, assignment of benefits, determining eligibility, and accounts collection and adjustment, please refer to the **Financial Eligibility and Billing Procedures** in Volume II of this manual.

Coding and Billing Requirements

The Federal Health Insurance Portability and Accountability Act (HIPAA) includes requirements regarding transactions and code sets to be used in recording services and claiming revenue. The rule, contained in CFR Chapter 42, took effect in October 2003 and includes a requirement for both standard Procedure Codes and Diagnosis Codes. Uniform Medical Record forms (see Section G, Quality Improvement) of this Manual reflect the required codes, and County QI staff regularly provides training on the use of the Service Record forms. Additional requirements for medical records come from the County's contract with the California Department of Mental Health; these requirements determine the nature of chart reviews during a Medi-Cal audit and the items for which financial recoupment of payment for services will be made by State or County reviewers. Following are current requirements and resources related to coding and billing:

- Services must be coded in compliance with the Management Information System Anasazi User Manual, Organization Provider Operations Handbook Volume II.
- Diagnoses must be coded using the International Classification of Diseases (ICD-9 CM, or ICD-10 when adopted). In general, a diagnosis is made using the fuller descriptions of the Diagnostic and Statistical Manual, 4th Edition, Text Revision (DSM-IV TR) and "crosswalked" to the correct service code for the Management Information System software (currently Ansazi) by the clinician. The service code should result in the highest level of specificity in recording the diagnosis.
- Services are recorded on the Service Record, which includes the Anasazi Service Code and the staff number. The Service Record is used to enter services to the MIS and will reflect the range of services actually in the provider's budget.

FALSE CLAIMS ACT

All HHSA employees, contractors and subcontractors are required to report any suspected inappropriate activity. Suspected inappropriate activities include but are not limited to acts, omissions or procedures that may be in violation of health care laws, regulations, or HHSA procedures. The following are examples of health care fraud:

- Billing for services not rendered or goods not provided.
- Falsifying certificates of medical necessity and billing for services not medically necessary.
- Billing separately for services that should be a single service.
- Falsifying treatment plans or medical records to maximize payments.

- Failing to report overpayments or credit balances.
- Duplicate billing.
- Unlawfully giving health care providers, such as physicians, inducements in exchange for referral services.

Any indication that any one of these activities is occurring should be reported immediately to the compliance officer:

Robert Borntrager
HHSA Compliance Officer
619.515.4246
Compliance.HHSA@sdcounty.ca.gov

HHSA employees, contractors and subcontractors may also use the HHSA **Compliance hotline** at **(866) 549-0004** to request information or report suspected in appropriate activities. This line provides direction to the caller on the option to remain anonymous.

The Federal False Claims Act

The Federal False Claims Act ("FCA") helps the federal government combat fraud and recovers losses resulting from fraud in federal programs, purchases, or contracts. 31 U.S.C. §§ 3729-3733.

Actions that violate the FCA include:

- Knowingly submitting (or causing to be submitted) a false claim to the U.S. Government for payment or approval;
- Knowingly making or using (or causing to be made or used) a false record or statement to get a false claim paid or approved by the Government;
- Conspiring to get a false claim allowed or paid by the Government;
- Delivering (or causing to be delivered) less property than the amount of the receipt, where the person with possession or control of the Government money or property intends to deceive the agency or conceal the property;
- Making or delivering a receipt without completely knowing that the receipt is true, where the person authorized to make or deliver the receipt intends to defraud the Government;
- Knowingly buying or receiving (as a pledge of an obligation or debt) public property from an officer or employee of the Government or a member of the Armed Forces who has no legal right to sell or pledge the property; or
- Knowingly making or using a false record to conceal, avoid, or decrease an obligation to pay money or transmit property to the Government.

"Knowing" and "Knowingly" means a person:

- Has actual knowledge of the information;
- Acts in deliberate ignorance of the truth or falsity of the information; or

- Acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.

"Claim" includes any request or demand for money or property (including those made under contract) to the Government or to a contractor, grantee, or other recipient, if any portion of the requested money or property is funded by or will be reimbursed by the Government.

A person or organization may be liable for:

- A civil penalty $5,500 to $11,000 for each false claim;
- Three times the amount of damages sustained by the Government due to the violations; and
- The costs of a civil suit for recovery penalties or damages.

If a *qui tam* plaintiff alleges a false claims violation, the complaint and a written disclosure of the evidence and information that the person possesses must be served on the Government. Once the action is filed, no person other than the Government is allowed to intervene or file a lawsuit based on the same facts.

Whistleblower Protection

An employee who has been discharged, demoted, suspended, threatened, harassed, or in any way discriminated against by his or her employer because of involvement in a false claims disclosure is entitled to all relief necessary to make the employee whole, including:

- Reinstatement with the same seniority status that the employee would have had but for the discrimination;
- Two times the amount of back pay plus interest; and
- Compensation for any special damage sustained because of the discrimination (including litigation costs and reasonable attorney's fees).

The protected false claims activities include investigation for, initiation of, testimony for, or assistance in a false claims action that has been or will be filed. An employee is entitled to bring an action in the district court for such relief.

The California False Claims Act

The California False Claims Act ("CFCA") applies to fraud involving state, city, county or other local government funds. The CFCA encourages voluntary disclosure of fraudulent activities by rewarding individuals who report fraud and allowing courts to waive penalties for organizations that voluntarily disclose false claims. Cal. Gov't Code §§ 12650-12655.

Actions that violate the CFCA include:

- Knowingly submitting (or causing to be submitted) a false claim for payment or approval;
- Knowingly making or using (or causing to be made or used) a false record or statement to get a false claim paid or approved;

- Conspiring to get a false claim allowed or paid by the state or by any political subdivision;
- Benefiting from an inadvertent submission of a false claim, subsequently discovering the falsity of the claim, and failing to disclose to the state or political subdivision within a reasonable time after discovery;
- Delivering less property than the amount of the receipt, where the person has possession or control of public property;
- Knowingly making or delivering a false receipt, where the person is authorized to deliver a document;
- Knowingly buying or receiving (as a pledge of an obligation or debt) public property from any person who has no legal right to sell or pledge the property; or
- Knowingly making or using a record to conceal, avoid, or decrease an obligation to pay money or transmit property to the state or local government.

"Knowingly" means the person or organization:

- Has actual knowledge of the information;
- Acts in deliberate ignorance of the truth or falsity of the information; or
- Acts in reckless disregard of the truth or falsity of the information. Proof of specific intent to defraud is not required.

"Claim" includes any request for money, property, or services made to the state or any political subdivision (or to any contractor, grantee, or other recipient), where any portion of the money, property, or services requested was funded by the state or any political subdivision.

The maximum civil penalty is $10,000, per claim. Persons who violate the CFCA may be liable to the state for three times the amount of damages that the state sustains because of the violation. The court can waive penalties and reduce damages for CFCA violations if the false claims are voluntarily disclosed. The CFCA does not apply to false claims of less than $500. Lawsuits must be filed within three years after the violation was discovered by the state or local official who is responsible for investigating the false claim (but no more than ten years after the violation was committed).

Liability to the State or Political Subdivision

A person or organization will be liable to the state or political subdivision for:

- Three times the amount of damages that the state or local government sustains because of the false claims violations;
- The costs of a civil suit for recovery of damages; and
- A civil penalty of up to $10,000 for each false claim.

Whistleblower Protection

Employers are prohibited from:

- Making or enforcing any type of rule or policy that prevents an employee from disclosing information to a government or law enforcement agency, or from investigating, initiating, testifying, or otherwise assisting in a false claims action; or
- Discharging, demoting, suspending, threatening, harassing, denying promotion to, or in any other manner discriminating against an employee because of his or her involvement in a false claims action.

If you have any questions about the HHSA Compliance Program or the Federal or State False Claims Acts please contact:

- **Bob Borntrager, CHC Compliance Officer at 619.515.4244 or by e-mail at: Compliance.HHSA@sdcounty.ca.gov**

C. ACCESSING SERVICES

Consistent with the Health and Human Services Agency's "No Wrong Door" policy, clients may access behavioral health, which encompasses mental health and alcohol and drug services through multiple points of entry. Clients may call the Access and Crisis Line (ACL), be referred by school personnel, CWS, Probation, or other child-serving organizations, or call or walk into a county clinic or an organization program directly. The ACL is the point of entry for accessing Fee-for-Service (FFS) providers.

In accordance with Title 9, California Code of Regulations requirements, organizational providers and County-operated clinics must maintain logs of all persons requesting Specialty Mental Health Services. Required information includes date of inquiry, Medi-Cal eligibility, ethnicity/language, name, phone number and relationship of caller, nature of request (emergent, urgent or routine) disposition with date/time and if/where referred. A sample copy of the **Request for Services Log** Form is located in *Appendix C. C.1*.

Service providers are additionally required to make referrals, track and report the number of families referred for Medi-Cal or Healthy Families insurance. There is a space provided to track this on the Request for Services Log in *Appendix C. C.1*.

Emergency Psychiatric Condition

Title 9 defines an "Emergency Psychiatric Condition" as a condition in which the client, due to a mental disorder, is an imminent danger to self or others or is immediately unable to provide for or utilize food, shelter or clothing. This situation indicates an immediate need for psychiatric inpatient hospitalization or psychiatric health facility services.

Goal for Services: Face-to-face clinical contact within one (1) hour of initial client contact/ referral.

Urgent Psychiatric Condition

Title 9 defines an "Urgent Psychiatric Condition" as a condition, which without timely intervention, is certain to result in an immediate emergency psychiatric condition.

Goal for Services: Face-to-face clinical contact within seventy-two (72) hours of initial client contact/referral.

Routine Condition

A "Routine Condition" is defined as a relatively stable condition and there is a need for an initial assessment for Specialty Mental Health Services.

Goal for Services: Face-to-face clinical contact within five (5) calendar days of initial client contact/referral.

Accessing Organizational Provider Outpatient Services or County Operated Program

If a client first accesses services by calling or walking into an organizational provider site or a county-operated program, the client can be seen and assessed, and the organizational provider authorizes services based on medical necessity and/or the SED criteria as outlined in California Welfare & Institutions Code Section 5600.3. (See Systems of Care section of this handbook for elaboration of the content of this code.) See Authorization/Reimbursement Section of this handbook for a description of organizational provider and county-operated program responsibility for registration of clients. AB2726 clients are assessed and authorized by the County of San Diego Special Education Services (SES) and referred to organizational providers as appropriate. Heathly Families clients need to be assessed and authorized for SED serviced through the Emergency Screening Unit (ESU).

Accessing Day Intensive and Day Rehabilitative Services

Day services are offered in school/community settings and as enhanced treatment services in residential facilities for the most severely emotionally disturbed children and youth who meet medical necessity. Referral and admission to all day services may come from AB2726 programs, Juvenile Probation, Child Welfare Services, or schools. All programs are MediCal certified and comply with MediCal standards regardless of funding source.

Authorization is required for all day services. Clients referred to day services shall begin treatment services within contract guidelines. Upon admission of the client, day programs shall comply with authorization procedures for day services as set forth in the DMH Letter No.: 03-03. An Administrative Services Organization (ASO) provides authorization for all day services. OptumHealth acts as the ASO. Reauthorization is required every three months for day intensive services and every six months for day rehabilitative services. A copy of OptumHealth's current Specialty Mental Health Services DPR form is available at https://www.ubhonline.com/publicSector and is included in *Appendix C. C.2. See Section D for information on Out of County clients and all other authorizations.*

ACCESS AND CRISIS LINE: 1-800-479-3339

OptumHealth operates the San Diego Access and Crisis Line (ACL) on behalf of the Mental Health Plan (MHP). The ACL, which is staffed by licensed and master's level counselors, provides telephone crisis intervention, suicide prevention services, mental health, alcohol and drug services information and referral 24 hours a day, 7 days a week. The ACL may be the

client or the family's initial access point into the MHP for routine, urgent or emergency situations.

All ACL staff are trained in crisis intervention, with client safety as the primary concern. Staff evaluates the degree of immediate danger and determines the most appropriate intervention (e.g., immediate transportation to an appropriate treatment facility for evaluation, or notification of Child or Adult Protective Services or law enforcement in a dangerous situation).

The ACL has Spanish-speaking counselors on staff. Other language needs are met through the Language Line, which provides telephonic interpreter services for approximately 140 languages at the point of an initial ACL screening. Persons who have hearing impairment may contact the ACL via the TTY line at (619) 641-6992.

Provider Interface with the ACL

- Use the ACL as an adjunct to provider services in emergencies and after hours. To provide the most effective emergency response and back-up to their own services, provider office voice mail messages should state, "If this is a mental health emergency or crisis, please contact the Access and Crisis Line at 1-800-479-3339."

- If a client is high risk and may be calling the ACL for additional support, the client's therapist or care coordinator may call (with client's approval) the ACL in advance on behalf of the client. To facilitate the most effective ACL response to the high-risk client's needs when he or she calls, please provide the ACL with all relevant clinical and demographic information.

Hours of Service Availability

In accordance with 42 CFR, providers serving Medi-Cal clients must ensure service availability by offering hours of operation that are no less than the hours of operation offered to commercial clients. If the provider serves only Medi-Cal clients, the hours of service availability must be the same for fee-for-service and managed care clients. Providers are also expected to ensure that hours of operation are convenient to the area's cultural and linguistic minorities and adhere to the specifics in the Statement of Work. The MHP QI Unit will monitor availability of service hours at the Site Review.

Available Language Assistance

Provider staff encountering consumers whose service needs cannot be determined on-site because of language barriers can contact the Access and Crisis Line for linkage to brief phone interpretation service to determine the client's service needs.

ACCESSING SERVICES

According to 42 CFR, clients shall be routinely asked, at the time of accessing services, about their needs for free language assistance. According to Title 9, providers must document the offer and whether linkage was made to interpreter service for clients requesting or needing translation services in threshold or other languages. BHS prohibits the expectation that family members, including minor children will provide interpreter services; however, if clients choose to use family or friends, this choice also should be documented.

Interpreters can be qualified staff members at the provider site. Consistent with the Cultural Competency Standards, contractors are encouraged to develop and maintain staff's language competency for threshold languages. If no qualified staff is available, with the approval of the program manager or designee, program staff can contact Interpreters Unlimited (for language interpreting) at (800) 726-9891 or Deaf Community Services (DCS) (for hearing impairment) at (619) 398-2488 to arrange for free language assistance. If for some reason DCS is unable to provide for sign language services, providers may call Network Interpreting as a back up only at (800) 284-1043. If there is a need to use Network Interpreting, providers should document why DCS was not utilized. As soon as the services have been rendered, the provider will fill out a **Service Authorization Form** (*Appendix C. C.3).* See also *Appendix C. C.4* for instructions on this use of this form.)

The completed form will be faxed to Interpreters Unlimited or Deaf Community Services or Network Interpreting (back up only). The interpreting services will then submit an invoice to the MHP.

To comply with State and federal regulations, providers must be able to provide information on Mental Health Plan (MHP) services to persons with visual or hearing impairment, or other disabilities, making every effort to accommodate an individual's preferred method of communication.

Service Priority for Outpatient Assessment Services

High

- Children and adolescents requiring emergency services should be assessed within one hour of contact with program. They may be seen at the program or referred to Emergency Screening Unit..
- Children and adolescents with Urgent referrals, defined as a condition that, without timely intervention, would very likely become an emergency, should be seen within 72 hours of contact with program.
- Children and adolescents being discharged from acute psychiatric hospital care shall be seen within one week of contact with program unless the referral is deemed Urgent, in which case they should be seen within 72 hours of contact with program.

- Children and adolescents requiring crisis services different from Urgent services should be assessed within one (1) day
- AB 2726 students stepping down from higher level of care (day treatment or residential) shall be assigned for treatment in a timely fashion as defined in the inter-agency agreement.
- Seriously Emotionally Disturbed (SED) children and adolescents take priority over routine admissions.
- AB 2726 students with outpatient services on the IEP shall be assigned for treatment as specified in Interagency Agreement.

Moderate

- Children and adolescents with moderate mental health needs who meet medical necessity criteria shall be provided with appropriate services based on the client needs as well as the program's Utilization Management process.

Low

- For children and adolescents with moderate to low-level mental health needs clinicians at all programs shall assist the parent/caregiver in accessing services within the region through the OptumHealth individual/group provider network, if the child is Medi-Cal eligible.

Client Selection of a Provider

In accordance with 42 CFR and Title 9, providers are to inform clients of their right to choose a provider and to obtain a list of MHP providers, including information on program site, hours of service, type of services offered, and areas of cultural and linguistic competence. Information about organizational providers is posted on the *Network of Care* website (www.networkofcare.org), and in the *Organizational Provider Resource Manual*, which may be obtained through Edith.Mohler@sdcounty.ca.gov. Information on fee-for-service providers is available from OptumHealth. When feasible, beneficiaries will be provided with the initial choice about the person who provides specialty mental health services, including the right to use culturally specific providers.

Note: Contractors shall report to the CMHS QI Unit and COTR any changes in location, hours or types of services offered to keep the Organizational Provider Resource Manual current. Providers will be surveyed periodically about cultural and linguistic capabilities.

Clients Who Must Transition to a New Provider

Good clinical practice indicates that the following should be implemented whenever possible:

- The client and caregiver should be informed of the impending change as soon as it is clinically indicated and possible, but at least 14 days prior to the final visit with the first program/provider.
- The client and caregiver should be informed of the client's right to request a new provider.
- Client and caregiver should be encouraged to voice their needs regarding provider's clinical and language capabilities, time of appointment, location of the new clinic or program, transportation, etc.
- Report transfer on **Suggestion and Provider Transfer Log, which is part of the Monthly Status Report**, *Appendix G. G.8.*
- The client should be assisted in making a first appointment with the new program.
- The old and new program must communicate as completely as possible, via case consultations, phone conversations, and release of discharge summaries and other chart materials.
- A thorough discharge summary (or a transfer note, if the client will continue in the same program) should be written and incorporated into the chart.
- Final outcome tools should be administered if the client will go to another provider program.
- A plan for emergency services should be developed with the client and caregiver, to include the ACL, the new program, and informal supports.

DUAL DIAGNOSIS CAPABLE PROGRAMS

Clients with co-occurring mental health and substance use issues are common in the public mental health system and present with complex needs. CMHS has adopted the Comprehensive, Continuous Integrated System of Care (CCISC) Model for individuals and families with co-occurring substance use and mental health disorders. Programs must organize their infrastructure to routinely welcome, identify, and address co-occurring substance use issues in the clients and families they serve. They shall provide properly matched interventions in the context of their program design and resources. For specific information regarding CCISC and dually diagnosed clients, please see **Section A** of this handbook.

UNDOCUMENTED CLIENTS

In accord with County and State policy, the Uniform Method of Determining Ability to Pay (UMDAP) does not require that a person have a specific period of residence in the county or state to qualify for services. Intent to reside in San Diego County is a necessary condition, and is established by the client's verbal declaration. This applies to foreign nationals, including undocumented immigrants. Without intent to reside in San Diego County, any client, regardless of citizenship, must be billed at full cost. However, persons known to be undocumented immigrants are eligible only for emergency services, such as an acute care hospital or the

Emergency Screening Unit, and services pursuant to an Individualized Education Program under Assembly Bill 2726.

D. AUTHORIZATION OF REIMBURSEMENT FOR SERVICES

All authorization requirements in this section must be completed for all treatment clients even if the services will be funded by a source other than Medi-Cal, such as SB90 and Mental Health Services Act (MHSA).

MEDICAL NECESSITY

Provider must demonstrate that each client receiving Specialty Mental Health services meets medical necessity. Authorization is performed through the MHP Utilization Management Process, using Title 9 (Section 1830.205) Medical Necessity criteria as summarized below. A complete description of Title 9, Medical Necessity Criteria for MHP Reimbursement of Specialty Mental Health Services can be found on the State website at www.calregs.com. For a copy of Title 9, please call the State Office of Administrative Law at 916-323-6225. Services provided to clients are reimbursable when the following criteria are met:

Outpatient and Day Services Clients:

- The client must have a diagnosis included in the current Diagnostic and Statistical Manual that is reimbursable for outpatient and day services as described in Title 9, Section 1830.205 (1).

AND

The client must have at least one of the following as a result of the mental disorder(s):

- A significant impairment in an important area of life functioning,
- A probability of significant deterioration in an important area of life functioning, or
- A probability that the client will not progress developmentally as is individually appropriate (for Medi-Cal beneficiaries under age 21).

AND

All of the following:

- The focus of proposed intervention is to address the impairment or potential impairment identified immediately above,
- The proposed intervention is expected to benefit the client by significantly diminishing the impairment or preventing significant deterioration in an important area of life functioning, and
- The condition would not be responsive to physical healthcare treatment.

Seriously Emotionally Disturbed (SED) Clients:

The priority population for Children's Mental Health Services, including clients seen under MHSA, is seriously emotionally disturbed (SED) children and youth. SED clients must meet the criteria for medical necessity and further are defined as follows (per California Welfare & Institutions Code Section 5600.3):

For the purposes of this part, seriously emotionally disturbed children or adolescents are those who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of the following criteria:

(A) As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:

(i) The child is at risk of removal from home or has already been removed from the home.

(ii) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.

(B) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

(C) The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

Note: AB2726 clients are not eligible for services through MHSA because MHSA services may not supplant other services.

Healthy Families

Clients may have Healthy Families as their 3rd party coverage/insurance. In the case of a client with Healthy Families, he/she must first be assessed to determine if he/she meets the criteria for services for children with Severe Emotional Disturbance (SED). This process is completed through the Emergency Screening Unit (ESU). Prior to providing mental health services to a client with Healthy Families insurance, it is the responsibility of each program to determine if the client has or has not already been assessed and authorized for SED services through the ESU. If not then the program should refer the client to the Emergency Screening Unit to complete the assessment process.

OUTPATIENT SERVICES

Outpatient Redesign

One of the overarching Health and Human Services Agency (HHSA) principles is efficient and effective access to our target populations. Effective 1/1/10, CMHS clients shall receive brief treatment services that focus on the one or two most important issues identified by the

client/family and conclude when those are stabilized. The short term, focused model shall be communicated at the onset of treatment so the client/family can maximize use of sessions and be prepared for conclusion of treatment.

Clients who meet the criteria for Title 9 medical necessity shall be eligible for up to 13 individual treatment sessions or up to 18 exclusively family and/or group treatment sessions (within a 12 month period). This will apply to MediCal, MHSA (indigent), and Healthy Families Severely Emotionally Disturbed (SED). Additional sessions may be authorized as clinically indicated. Utilization Management shall be completed at the program level by a licensed clinician.

For detailed information and requirements regarding authorization of outpatient services, see *Appendix A.D.4*.

Authorization of Reimbursement of Services

The San Diego County MHP defines Children's Mental Health clients as children and youth under 18 years of age; at times those over 18 years of age may be served if they are receiving services pursuant to SB90 or if continuing in a CMHS program is clinically indicated. Clients may access the services of organizational providers and county-operated facilities in the following ways:

- Calling the organizational provider or county-operated program directly
- Walking into an organizational provider or county-operated program directly
- Calling the Access and Crisis Line at 1-800-479-3339
- Referrals from ESU

A client may access services by calling or walking into an organizational provider or county-operated program; the client shall be screened or assessed by the provider. After completion of an assessment and when additional services are offered, that provider is responsible for entering administrative and clinical information into all the appropriate fields in the Management Information System (MIS). Providers must register clients, record assignment and service activities, and update the CSI information in MIS. (See the Management Information System section of this handbook for a description of how MIS supports these provider activities.)

If, after completing the assessment, the clinician determines that medical necessity criteria for specialty mental health services are not met, the MediCal client will be issued an **NOA-A** (*Appendix D. D.1)* and **NOA-Back** *(Appendix D.D. 2*) (which must also be documented in the **NOA Log** tab of the Monthly Status Report (*Appendix G. G.13*) and their beneficiary rights shall be explained. If a client will receive day services (either intensive or rehabilitative) on the same day that the client receives Mental Health Services (Individual, Group, Family, or Collateral. Etc.), authorization for the Mental Health Service must be determined in accordance with the

Day Treatment Ancillary UR process applicable to outpatient providers. Authorization is obtained from OptumHealth through the day treatment provider. (See Utilization Review.)

If the Access and Crisis Line (ACL) refers a client to an organizational provider or to a county-operated facility, ACL enters the client information in the MIS. The provider is then responsible for insuring all client information is correct and complete. The provider is also responsible for recording all ongoing activity for that client into the MIS. This information includes, but is not limited to, assignment and service activities, the primary diagnosis, the name of the single accountable individual, and all client assignment closings.

Utilization Management

The MHP has delegated responsibility to outpatient County operated and contracted organizational providers to perform utilization management for specialty mental health services, outpatient services, medication services, and case management services. Authorization decisions are based on the medical necessity criteria delineated in Title 9 of the California Code of Regulations. Each delegated entity shall be accountable to the Children's Mental Health Director and shall follow the Utilization Management processes established for children's mental health programs.

At the time a client is admitted to a program, clinicians shall perform a face-to-face assessment to ensure that each new client meets medical necessity criteria for specialty mental health services. The clinician shall complete the County's applicable Behavioral Health Assessment Form and ensure that all required domains are completed.

The Utilization Management Committee operates at the program level and must include at least one licensed clinician. The Utilization Management Committee bases it decisions on whether medical necessity is still present, whether the proposed services are likely to assist in meeting the Client Plan goals, and additional criteria (*see Appendix A.D.4*). To assist in its determination, the Utilization Management Committee or clinician receives a UM Request and Authorization form (which reports current client functioning in quadrants for various domains) and a new Client Plan to cover the interval for which authorization is requested. Medication only clients are not included in the Utilization Management process as they are subject to medication monitoring. For detailed information and requirements regarding Utilization Management for outpatient programs, see *Appendix A.D.4.*

If client is concurrently provided day and outpatient services, then ancillary authorization must occur through day program and OptumHealth because the day services cycle supersedes outpatient UM. In these cases the outpatient program must also complete UR in accordance with the procedure described in CMHS Outpatient Redesign *(see Appendix A.D. 4.)* .

AUTHORIZATION OF REIMBURSEMENT FOR SERVICES

AB2726 OUTPATIENT SERVICES

The process for authorization of outpatient services provided by AB2726 service providers was revised effective 3/01/10. The goals of the redesign are to offer more focused delivery of outpatient services, for services to be individualized, flexible and dynamic, and for services to be more closely aligned with the student's Individual Education Program (IEP) cycle.

Services shall be individualized on each student's IEP and will be strategically planned to maximize efficiency. Ongoing dialogue with families and school contact about focused treatment and realistic expectations of treatment sets the stage for success of this model. Consistent communication with the family and the school representative is essential.

- AB2726 Special Education (SES) staff at the initial IEP meeting shall recommend a definitive number of outpatient mental health treatment sessions with a distinct start date and an end date that coincides with the annual IEP date. The IEP shall act as the authorization document; there will be no separate Utilization Management (UM) process.
- Services may include individual, group and/or family sessions which will be offered for a specified number of authorized treatment sessions until the annual IEP review date.
- Collateral, case management and medication management services, if appropriate, will be offered in addition to the identified treatment sessions.
- Outpatient providers must ensure that the client meets medical necessity for outpatient mental health services.

For detailed information and requirements regarding authorization of AB2726 outpatient services, see *Appendix A.D.5*.

DAY REHABILITATION AND DAY INTENSIVE

Authorization of Reimbursement of Services

Prior to admission to the program, each client must have a face-to-face assessment to establish medical necessity. The assessment must document that a recommendation for day program was made in the course of a formal assessment, lower levels of care have been tried unsuccessfully or would be unsuccessful if attempted, and a highly structured mental health program is needed to prevent admission to a more intensive level of care.

The Initial Day Program Request (DPR) must be completed/submitted along with a Specialty Mental Health Services DPR if the client receives ancillary services on the same day as day program services. Continued requests that are made must be accompanied with a Specialty Mental Health Service DPR if applicable. Utilization review will be completed by OptumHealth according to necessity criteria for the level of day service.

These service criteria essentially state that the client cannot be served at a lower level of care and that a recommendation for day services has been made. Day services must be reauthorized every 3 months for day intensive and every 6 months for day rehabilitative. If medical or service necessity criteria are not met, the MediCal client will be issued an NOA-A (which must also be documented in the NOA log) and the beneficiary rights shall be explained. In the event that the provider has received a denial of authorization from OptumHealth, an **NOA-B** (*Appendix D . D.3*) shall be issued by OptumHealth.

Notes: *DPRs are to be completed for all day services clients (optional for clients from out-of-county; which require a Service Authorization Request (SAR)).

****** Note: it is the responsibility of each program to determine insurance coverage (or lack of) in order to decide which process to follow:

*DPRs are faxed to OptumHealth for review for the following situations:

-Client has MediCal or Healthy Families ONLY

-Clients with primary private insurance and secondary MediCal AND the primary private insurance has provided a denial of payment (only then can MediCal be billed for services)

*DPRs are NOT sent in to OptumHealth for the following situations:

*Clients with no insurance

*Clients with a primary private insurance

*Client with AB2726 only

*Clients with a primary private insurance and secondary MediCal (AND the parents have declined to sign an Assignment of Benefits)

*Initial authorizations may not be submitted prior to the opening of the assignment.

*Authorization cycles are based on months and not days (i.e. for Day Intensive an authorization cycle may look like: Initial DPR 1/1/08-3/31/08, Continued DPR 4/1/08 – 6/30/08, etc.).

*OptumHealth will review the DPR and determine authorization within 14 business days. The provider may check directly in the MIS for authorization or contact OptumHealth if there are questions. Authorization letters will no longer be sent out to the program.

*Authorization will include day service and ancillary services for each client. Authorizations for day treatment and ancillary services are entered separately based on the timeline of the receipt of the request by OptumHealth.

*Letters of denial of authorization will be sent to the program for the following reasons:

-Client does not show as MediCal eligible

-Client has a primary private insurance

-Client has a primary private insurance and secondary MediCal – but no denial of payment has been provided by the private insurance (therefore MediCal may not be billed)

*Programs are responsible to check on a monthly basis all MediCal and UMDAP clients for eligibility and update the MIS as appropriate.

* DPRs should be filed in the medical record in the Plans section, or be accessible upon request.
* Retroactive authorizations should not be requested for services more than 9 months in the past. Inform your COTR via e-mail when submitting a retroactive authorization request.
****** If any of the above is not done correctly, OptumHealth will return the DPR for correction and services will not be authorized until the corrections are made and the form is faxed back to OptumHealth for review.
* If you have any questions regarding the DPR process including following up with authorization questions, please contact: OptumHealth at (800) 798-2254 option #4.

Utilization Review

Utilization review of day intensive and day rehabilitation services for MediCal and Healthy Families clients is delegated to OptumHealth.

OUT OF COUNTY MEDI-CAL CLIENTS

Authorization of Reimbursement of Services
Children in foster care, Aid to Adoptive Parents (AAP), and Kinship Guardianship Assistance Payment Program (KinGAP), when placed outside their county of origin have had difficulty receiving timely access to specialty mental health services. Senate Bill (SB) 785 intends to improve the timely access to these services by transferring the responsibility for the provision of specialty mental health services to the county of residence of foster, AAP, and KinGAP children. DMH Information Notice No. 08-24 and 09-06.

Outpatient Programs Procedure(s) for Medi-Cal Eligible Children in a Foster Care Aid, AAP, and KinGAP Codes:

1. Child Welfare Services (CWS) Social Worker from the county of origin instructs legal guardians to contact San Diego Administrative Services Organization (ASO), at 1-800-479-3339 for services referrals. The ASO makes a referral to a Fee-For-Service (FFS) or an organizational provider.
2. The program providing the services will submit the Service Authorization Request (SAR*)* to the county of origin for authorization and signature *(see Appendix A.D.6 for (SAR) Out of County Organizational Providers Only (MH5125).*
3. The County of San Diego provider will provide services, if the child meets Medical Necessity Criteria and the county of origin authorizes the provision of services. The service provider is required to inform the child welfare agency of the county of origin of the services being provided, if requested and if the information is available, in accordance with the privacy standards contained in the Health Insurance Portability and Accountability Act (HIPAA) and Medi-Cal confidentiality requirements.

4. Services shall be entered into the Anasazi Management Information System (MIS) by the San Diego provider.
5. The County of San Diego will submit the claim for services directly to the State Department of Mental Health.

Procedure(s) for Medi-Cal Eligible Children in a Day Program:

1. Day Programs will inform their COTR when serving out of county Medi-Cal clients.
2. Day Programs first priority is to serve San Diego County clients then out of county Medi-Cal clients.
3. Day Programs will coordinate with county of origin for SAR authorization. If county of origin SAR authorization is delayed, services may be provided when the reason for delay is administrative in nature and not a clinical denial.
4. Program submits signed SAR to OptumHealth.
5. Program additionally submits a DPR to OptumHealth. A DPR is not required when the following information is provided with the signed SAR:
   a. Unit and subunit on the SAR
   b.CFARS Rating (new CFARS Rating completed at each UM cycle)
6. Services are entered into the Anasazi (MIS) by the San Diego provider.
7. The County of San Diego will submit the claim for services directly to the State Department of Mental Health.
8. All County of San Diego paperwork must be completed as well as any alternate forms/information required by the county of origin.
9. When day services are provided out of county, an alternative Day Program Request Form may be used if it contains all required elements. Approval for its use is to be obtained by either the COTR or Program Manager of Quality Improvement.

THERAPEUTIC BEHAVIORAL SERVICES

Authorization of Reimbursement of Services

Clients are referred to County TBS as the central point of contact. Referrals are screened to ensure they are Medi-Cal eligible and to confirm the client/family willingness to participate in the services. Clients are then referred to a TBS contract provider within one to three business days of receipt by the County. The referred client will be assessed for eligibility criteria according to California Department of Mental Health guidelines provided in DMH Letter 99-03 and DMH Notice 02-08. The Contractor conducts this assessment and client must meet the class, service, and other TBS criteria prior to services being delivered.

Utilization Review

Authorization management for extended Therapeutic Behavioral Services is retained by the MHP. If a client requires more than four (4) months or 25 hours of coaching per week of TBS, the Contractor shall submit a request for authorization to County TBS. Authorization is not needed for "stabilization services" where the client is receiving one to two hours a week for a couple of weeks to ensure stability of treatment gains.

Authorization for services for San Diego clients placed out of county is required through County TBS.

QI PROGRAM MONITORING

The MHS Children's Quality Improvement Unit shall monitor each organizational provider and county operated program for compliance with these requirements, to assure that activities are conducted in accordance with both State and MHP standards. If the delegated entity's activities are found not to be in compliance, the MHP shall require that a corrective action plan be formulated. Progress toward change will be effected through direct management in the case of a County operated program, or through contract monitoring in the case of a contractor. The Quality Improvement Unit will prioritize and discuss opportunities for improvement with any provider having performance problems. Corrective action plans shall be monitored for implementation and appropriateness as deemed necessary, between annual reviews. If the provider does not successfully correct the problems within the stated timeframe, the County will take appropriate remedial action.

Financial Eligibility and Billing Procedures

Each provider is responsible for specific functions related to determining client financial eligibility, billing and collections. The *Organizational Provider Financial Eligibility and Billing Procedures Handbook* (listed as "*Financial and Eligibility User Manual"* at https://www.ubhonline.com) is provided by CMHS for providers as a guide for determining financial eligibility, billing and collection procedures. This handbook includes the following procedure categories:

- Using the MIS.
- Adding a new client.
- Assignment opening/closing and service entry.
- Determining financial eligibility.
- Claims, billing, and posting procedures.
- Training and technical assistance.

AUTHORIZATION OF REIMBURSEMENT FOR SERVICES

This handbook is not intended to replace the *Management Information System Anasazi Users Manual* (https://www.ubhonline.com) or intended to be a comprehensive "Insurance and MediCal Billing" guide. It is meant to augment existing resource materials.
These are "living" handbook/manuals that are revised as new processes/procedures are implemented.

E. INTERFACE WITH PHYSICAL HEALTH CARE

COORDINATION WITH PRIMARY CARE PHYSICIANS

Coordination of care between mental health care providers and health care providers is necessary to optimize the overall health of a client. All providers are expected to coordinate mental health care with a client's Primary Care Physician and should have a policy and procedure in place regarding this coordination of services. Over 50% of Medi-Cal beneficiaries are enrolled in one of seven Health Maintenance Organizations (HMOs) that are part of Healthy San Diego. They are required by the MHP to obtain a Release Of Information (ROI) from the client during the first visit to facilitate coordination with the client's Primary Care Physician. Included as an Attachment to this handbook is the Healthy San Diego Physical and Mental Health Care Coordination Form, which providers may use to facilitate or enhance coordination of care with the client's Primary Care Physician. **When a client comes in with no healthcare coverage, provider shall refer the client to Medi-Cal or the Healthy Families Program.**

NOTE!

See the "**Plan Partner Identification for Pharmacies**" (*Appendix E. E.2*) for contact information for the Healthy San Diego Health Plans.

Pharmacy and Lab Services

HMO Medi-Cal Beneficiaries

Each HMO has contracts with specific pharmacies and laboratories. Providers prescribing medication or lab tests need to be aware of which pharmacy or laboratory is associated with each client's HMO in order to refer the client to the appropriate pharmacy or lab. (See the chart of such affiliations in the Attachment Section of this Handbook (*Appendix E, E.1*.) The client's HMO enrollment card also may have a phone number that providers and clients can check in order to identify the contracted pharmacy or lab.

Psychiatrists may order the following lab studies without obtaining authorization from the client's Primary Care Physician:

- CBC
- Liver function study
- Electrolytes
- BUN or Creatinine
- Thyroid panel
- Valproic acid
- Carbamazapine
- Tricyclic blood levels
- Lithium level.

All other lab studies require authorization from the client's Primary Care Physician. It is recommended that each provider contact the client's HMO Member Services Department or Primary Care Physician to determine which lab test(s) require authorization from the client's Primary Care Physician.

Medi-Cal Beneficiaries Not Enrolled in an HMO

Medi-Cal beneficiaries who are not members of an HMO may use any pharmacy or lab that accepts Medi-Cal reimbursement.

Non-Medi-Cal Beneficiaries

Non-Medi-Cal beneficiaries who meet financial eligibility requirements being seen at County operated clinics may have their prescriptions filled at little or no cost at a county mental health clinic, or the Health and Human Services Agency Pharmacy at the Health Services Complex, 3851 Rosecrans Street, San Diego, California, 92110.

Contracted providers shall provide medications to non-Medi-Cal clients who meet financial eligibility requirements.

Contractor shall comply with the Medi-Cal Drug Formulary for Mental Health Services.

Providers shall make every effort to enroll clients in low cost or free medication programs available through pharmaceutical companies or obtain free samples to offset the cost of medication.

PHYSICAL HEALTH SERVICES WHILE IN A PSYCHIATRIC HOSPITAL

Healthy San Diego Recipients

The client's Healthy San Diego HMO is responsible for the initial health history and physical assessment required for admission to a psychiatric inpatient hospital. The client's HMO also is responsible for any additional or ongoing medically necessary physical health consultations and treatments. The HMO contracted provider must perform these services unless the facility obtains prior authorization from the HMO to use another provider.

The MHP contracted psychiatrist is responsible for obtaining the psychiatric history upon admission and for ordering routine laboratory services tests. If the psychiatrist identifies a physical health problem, he or she contacts the client's HMO to request an evaluation of the problem. If the psychiatrist determines further laboratory or other ancillary services are needed,

the contracted hospital must obtain the necessary authorizations from the client's HMO. (See *Appendix E. E.2* – **Healthy San Diego Physical and Mental Care Coordination Form**).

Medi-Cal Beneficiaries Not Enrolled in Healthy San Diego Health Plans)

For those Medi-Cal eligible clients who are not members of a Healthy San Diego HMO, physical health services provided in a psychiatric hospital are reimbursed by Medi-Cal.

TRANSFERS FROM PSYCHIATRIC HOSPITAL TO MEDICAL HOSPITAL

Psychiatric hospitals may transfer a client to a medical hospital to address a client's medical problems. The psychiatric hospital must consult with appropriate HMO staff to arrange such a transfer for physical health treatment. It is the responsibility of the HMO to pay for transportation in such cases. The Optum Health Medical Director and the HMO Medical Director will resolve any disputes regarding transfers.

Medical Transportation

Healthy San Diego HMOs will cover, at the Medi-Cal rate, all medically necessary emergency and non-emergency medical transportation services to access Medi-Cal covered mental health services. HMO members who call the ACL for medical transportation are referred to the Member Services Department of their HMO to arrange for such services.

HOME HEALTH CARE

Beneficiaries who are members of one of the Healthy San Diego HMOs must request in-home mental health services from their Primary Care Physician. The HMO will cover at the Medi-Cal rate home health agency services prescribed by a Plan provider when medically necessary to meet the needs of homebound members in accordance with its Medi-Cal contract with the State DHS. The MHP will pay for services solely related to the included mental health diagnoses. The HMO case manager and the Primary Care Physician coordinate on-going in-home treatment. The HMO is responsible for lab fees resulting from in-home mental health services provided to Medi-Cal members of the HMO.

HEALTHY FAMILIES ENROLLEES WHO ARE REFERRED FOR SERVICES AT CMHS

The Healthy Families Program provides health insurance for children up to their 19th birthday whose family income is between 100 and 250 percent of the federal poverty level, and are therefore not eligible for Medi-Cal. The Healthy Families Program (HFP) provides a basic mental health benefit, including psychiatric hospitalization, but some youngsters cannot be

adequately served within the limits of the HFP. Such youngsters are referred to the Emergency Screening Unit (ESU) to determine if they meet the criteria for Seriously Emotionally Disturbed youth as defined by the California Welfare and Institutions Code 5600.3. If the determination is positive, the youngster becomes eligible for the full range of medically necessary mental health services available though Short/Doyle Medi-Cal and MHSA. These services are to be provided to the extent resources allow. Referrals to Organizational Providers will be through the ESU only. Provider Programs who receive such a referral are required to verify monthly that the child or adolescent has a Medi-Cal aid type of 9H. The services should be billed under the program's usual procedure codes. Date of discharge shall be determined by the treating program in accordance with current outpatient Utilization Review criteria, or by agreement with the child and caregiver. Contact the Program Manager at ESU for more information.

(Coordination of Physical and Mental Health Care) Clinical Consultation and Training

Beneficiaries with less severe problems or who have been stabilized may be referred back to their Primary Care Physician for continuing treatment. To help support treatment by the Primary Care Physician, the MHP as well as organizational providers and county operated programs shall make clinical consultation and training, including consultation and training on medications, available to a beneficiary's health care provider for beneficiaries whose mental illness is not being treated by the MHP or for beneficiaries who are receiving treatment from another health care provider in addition to receiving specialty mental health services from the MHP. Efforts shall be made to provide consultation and training to Medi-Cal Managed Care Providers, Primary Care Providers who do not belong to a Medi-Cal Managed Care Plan and to Federally Qualified Health Centers, Indian Health Centers, or Rural Health Centers.

F. BENEFICIARY RIGHTS & ISSUE RESOLUTION

Client Rights and Protections Under Federal Code

According the Title 9 and 42 CFR 438.100, the MHP is responsible for ensuring compliance with consumer rights and protections. Providers, as contractors of the MHP, are also required to comply with all applicable regulations regarding consumer rights and protections. These rights and protections from 42 CFR can be summarized as follows:

- *Dignity, respect, and privacy*. Each managed care enrollee is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.
- *Receive information on the managed care plan and available treatment options.* Each managed care enrollee is guaranteed the right to receive information on the managed care plan and its benefits, enrollee rights and protections, and emergency care, as well as available treatment options and alternatives. The information should be presented in a manner appropriate to the enrollee's condition and ability to understand.
- *Participate in decisions*. Each managed care enrollee is guaranteed the right to participate in decisions regarding his or her health care, including the right to refuse treatment.
- *Free from restraint or seclusion*. Each managed care enrollee is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- *Copy of medical records*. Each managed care enrollee is guaranteed the right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR, Part 164.
- *Right to health care services.* Each enrollee has the right to be furnished health care services in accordance with CFR, Title 42, Sections 438.206-210.

In accordance with 42 CFR and Title 9, the MHP Quality Improvement Unit distributes the Guide to Medi-Cal Mental Health Services, which contains information on client rights, as well as a description of the services available through the MHP, and the avenues to obtain resolution of dissatisfaction with MHP services.

Note: *New clients must receive a copy of the Guide to Medi-Cal Mental Health Services when they first obtain services from the provider and upon request, thereafter. (Handbooks are available in threshold languages of English, Spanish, Vietnamese, Arabic and Tagalog.) Additional copies may be obtained from the MHP Quality Improvement Unit at (619) 563-2788.*

Additional Client Rights

- **Provider Selection**

  In accordance with 42 CFR 438.6 and Title 9, providers are reminded that clients have the right to obtain a list of MHP providers, including information on their location, type of services offered, and areas of cultural and linguistic competence. (See Accessing Services section in this Handbook for details.)

- **Second Opinion**

  If the MHP or its designee determines that a client does not meet Title 9 Medical Necessity Criteria for inpatient or outpatient mental health services, a client or someone on behalf of the client, may request a second opinion. A second opinion from a mental health clinician provides the client with an opportunity to receive additional input on his or her mental health care. As the MHP designee, OptumHealth is responsible for informing the treating provider of the second opinion request and for arranging the second opinion with an MHP contracted individual provider.

  The second opinion provider is required to obtain a release of information from the client in order to review the client's medical record and discuss the client's treatment. After the second opinion evaluation is completed, the second opinion provider forwards a report to the MHP Program Monitor/COTR for review. If a second opinion request occurs as the result of a denial of authorization for payment, the MHP Medical Director may uphold the original denial decision or may reverse it and authorize payment.

- **Transfer from One Provider to Another**

  Clients have a right to request a transfer from one Medi-Cal provider to another within or outside of a program. These transfer requests shall be recorded on the **Client Suggestions and Provider Transfer Request tab of the Monthly Status Report**. Documentation in the Log shall include the date the transfer request was received, whether the request was to a provider within or outside of the program, and the relevant code showing the reason for transfer if specified by the client. The Log shall be submitted with the provider's Monthly Status Report.

- **Right to Language, Visual and Hearing Impairment Assistance**

  Clients shall be routinely informed about the availability of free language assistance at the time of accessing services. CMHS prohibits the expectation that the client use family or friends for interpreter services. However, if the client so chooses, this choice should be documented in the client record. For more complete information about linking clients to free interpreter services, please see the Accessing Services section of this Handbook.

Providers must also be able to provide persons with visual or hearing impairment, or other disability, with information on Mental Health Plan Services, making every effort to accommodate individual's preferred method of communication, in accordance again with Title 9 and CMHS.

Advance Health Care Directive Information

Federal Medicaid regulations (42 CFR 422.128) require the MHP to ensure that all adults over age 18 and emancipated minor Medi-Cal beneficiaries are provided with information about the right to have an Advance Health Care Directive. In order to be in full compliance with this regulation, it is necessary that all eligible clients be informed of the right to have an Advance Health Care Directive at their first face-to-face contact for services, or when they become eligible (upon their 18 birthday or emancipation). An Advance Health Care Directive is defined in the 42 CFR, Chapter IV, Part 489.100 as "a written instruction such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated." Generally, Advance Health Care Directives deal with how physical health care should be provided when an individual is incapacitated by a serious physical health care condition, such as a stroke or coma, and unable to make medical treatment decisions for himself/herself.

In order to be in compliance with the Federal regulations (42 CFR, Chapter IV, Section 422-128), providers shall do the following for new adult or emancipated clients:

1. Provide written information on the client right to make decisions concerning medical treatment, including the right to accept or refuse medical care and the right to formulate Advance Directives, at the first face-to-face contact with a new client, and thereafter, upon request.
2. Document in the client's medical record that this information has been given and whether or not the client has an existing Advance Directive.
3. If the client who has an Advance Directive wishes to bring in a copy, the provider shall add it to the client's current medical record.
4. If a client is incapacitated at the time of initial enrollment and unable to receive information, the provider will have a follow-up procedure in place to ensure that the information on the right to an Advance Directive is given to the client at the appropriate time. In the interim, the provider may choose to give a copy of the information to the client's family or surrogate.
5. Not condition the provision of care or otherwise discriminate against an individual based on whether or not he or she has an Advance Directive.
6. Should the situation ever arise, provide information about the State contact point to clients who wish to complain about non-compliance with an Advance Directive.

The MHP is providing an informational brochure on Advance Directives, available in the threshold languages, which can be given out to new clients or members of the community who request it. Copies may be obtained through the MHP QI Unit by calling (619) 563-2788, or providers may duplicate their own copies. The MHP will also be responsible for notifying providers of any changes in State law regarding Advance Directives within 90 days of the law change.

Providers are expected to formulate their own policies and procedures on Advance Health Care Directives and educate staff. Because of the legal nature of Advance Directives, providers may wish to consult with their own legal counsel regarding federal regulations.

Periodic Notice of Clients' Rights

In accordance with DMH regulations, written and oral information explaining the grievance/appeal process and the availability of a State Fair Hearing for Medi-Cal beneficiaries shall be provided to new clients upon first admission to Mental Health Services, along with the Guide to Medi-Cal Mental Health Services. The date of this activity shall be reflected on the Behavioral Health Assessment signature page. Information on the Beneficiary Problem Resolution Process and State Fair Hearing Rights must be provided annually and documented on the Behavioral Health Assessment signature page.

BENEFICIARY PROBLEM RESOLUTION PROCESS

San Diego County Mental Health Services is strongly committed to honoring the rights of every consumer to have access to a fair, impartial, effective process through which the consumer can seek resolution of a problem encountered in accessing or receiving quality mental health services. All contracted providers are required to participate fully in the **Beneficiary Problem Resolution Process** (*Appendix F, F.1)*. Providers shall comply with all aspects of the Process, including the distribution and display of the appropriate beneficiary protection materials, including posters, brochures and grievance/appeal forms as described in the Process. When a provider is notified by the contracted advocacy organization, the Consumer Center for Health Education and Advocacy (CCHEA) or JFS Patient Advocacy Program that a client has filed a grievance or appeal about that provider's program or staff, the provider shall cooperate with the investigation and resolution of the client's concerns in a timely manner as specified in the Process.

Consumers shall not be subject to any discrimination, penalty, sanction or restriction for filing a grievance/appeal. The consumer shall not be discouraged, hindered or otherwise interfered with in seeking or attempting to register a grievance/appeal. Additionally, the consumer is not required to present a grievance/appeal in writing and shall be assisted in preparing a written grievance/appeal, if requested.

In accord with 42 CFR and Title 9, the County of San Diego Mental Health Beneficiary Problem Resolution Process has been streamlined, some terms redefined, and strict timelines added. An

opportunity for provider appeals has also been added, as well as a clinical review of grievances and appeals concerning clinical issues. The provider continues to play an important part in this process as follows:

Problem Resolution at Provider Sites

In a continuation of past practice to most quickly and efficiently make providers aware of and resolve problems, clients are encouraged to direct their suggestions to program staff or management. This can be done orally or in writing. In attempting to reach resolution consistent with confidentiality requirements, staff or management shall utilize whatever information, resources and/or contacts the consumer agrees to. Provider will log all client reported problems in the Client Suggestions and Provider Transfer Request Log. In order to preserve client confidentiality, this log must be kept in a secure area. This Log shall be submitted with the provider's Monthly Status Report.

Providers shall inform all clients about their right to file a grievance with one of the MHP's contracted advocacy organizations if the client has an expression of dissatisfaction about any matter, is uncomfortable approaching program staff, or the dissatisfaction has not been successfully resolved at the program. Clients should feel equally welcomed to bring their concerns directly to the program's attention or to seek the assistance of one of the advocacy organizations.

At all times, Grievance and Appeal information must be readily available for clients to access without the need for request. Each provider site shall have posters, brochures, and grievance/appeal forms in threshold languages, and addressed envelopes available to clients. These materials shall be displayed in a prominent public place.

Grievance Process

Timeline: 60 days from receipt of grievance to resolution, with a possible 14-day extension for good cause.

A "grievance" has been defined as an expression of dissatisfaction about any matter other than an action. JFS Patient Advocacy facilitates the grievance process for clients in inpatient and other 24-hour residential facilities. CCHEA facilitates the grievance process for outpatient and all other mental health services. These advocacy services will contact providers within three (3) days of receiving written permission from the client to represent him/her. Securing this permission can be difficult and time consuming. In order to be in compliance with the mandated federal timeline, providers shall work closely with the Advocacy organization to find a mutually agreeable solution to resolve the grievance quickly.

If a grievance or appeal is about a clinical issue, CCHEA and JFS Patient Advocacy Program, as required by 42 CFR, will be utilizing a clinician with appropriate clinical expertise in treating the client's condition to review and make a decision about the case.

Appeal Process

Timeline: 45 days from receipt of appeal to resolution, with a possible 14-day extension for good cause.

Appeals are reviews of actions by the MHP regarding provision of services through an authorization process, including:

- Reduction or limitation of services
- Reduction, suspension or termination of a previously authorized service
- Denial of, in whole or part, payment for services
- Failure to provide services in a timely manner.

See the Beneficiary Problem Resolution Process for details. The Advocacy organization will contact the provider within three (3) working days of receiving the written permission to represent the client. Again, the provider's cooperation with the Advocacy organization to find a mutually agreeable solution is necessary to meet the strict mandated timelines in resolving the problem. The advocacy organization shall investigate the appealed matter and make a recommendation to the MHP. The MHP (Local Mental Health Director or designee) will review the recommendations of the advocacy organization and make a decision on the appealed matter.

Note: A decision by a therapist to limit, reduce, or terminate a client's service is considered a clinical decision and cannot be the subject of an appeal; however, it can be grieved.

Expedited Appeal Process

Timeline: Three (3) working days, with a possible 14-day extension for good cause.

When the standard appeal process could jeopardize a client's life, health or functioning, an expedited appeal may be filed for by the Advocacy organization, necessitating a very rapid turnaround from grievance to resolution. The advocacy organization will notify the provider as soon as possible, but in less than two (2) working days. The Mental Health Director or designee will make a decision on the appeal on the third working day.

State Fair Hearings

Medi-Cal beneficiaries filing an appeal may request a State Fair Hearing, after using the County Beneficiary Problem Resolution Process whether or not they have received a Notice of Action within 90 days after the completion of the Beneficiary Problem Resolution Process. State Fair Hearings are further discussed in the Beneficiary Problem Resolution Process.

Provider Appeal Process

If the provider and advocacy organization cannot successfully resolve the client's grievance or appeal, the advocacy organization will issue a finding, to be sent to the client, provider and Mental Health Director, which may include the need for a Plan of Correction to be submitted by the provider to the Mental Health Director or designee in 10 days. In the rare instances when the provider disagrees with the disposition of the grievance/appeal and/or does not agree to write a Plan of Correction, the provider may write to the Mental Health Director within 10 days, requesting an administrative review. The Mental Health Director or his designee shall have the final decision about needed action. Please see the Beneficiary Problem Resolution Process for details of this portion of the process.

Monitoring the Beneficiary Problem Resolution Process

The MHP, operating from a shared concern with providers about improving the quality of care and service, will view feedback from the grievance/appeal process as a reflection of potential problems with service effectiveness and/or efficiency and as an opportunity for positive change. Information on problems may be incorporated into the ongoing contract monitoring and/or credentialing process.

CLIENT NOTIFICATION OF ACTION ON SERVICES (NOA PROCESS)

The State has developed the following forms to be used to notify clients about service provision:

Notice of Action-Assessment (NOA-A)

All Children's programs (County and contract) serving Medi-Cal clients shall follow procedures for issuing NOA-A forms for Medi-Cal beneficiaries. In accordance with Title 9, Section 1850.210, an NOA-A shall be issued to a Medi-Cal client when services are requested and medical necessity criteria are not met upon a face to face assessment and therefore no services are appropriate in the mental health system. Issuing of an NOA-A begins the 90-day period that a beneficiary has to file for a State Fair Hearing.

The NOA-A form informs the Medi-Cal beneficiary of the following:

- Reason for denial based on Title 9, California Code of Regulations
- Beneficiary's right to a second opinion
- The grievance/appeal process
- Right to a State Fair Hearing (once local process has been exhausted)
- Criteria for an expedited State Fair Hearing
- Explanation of the circumstances under which a specialty mental health service will be continued if a State Fair Hearing is requested
- Method by which a hearing may be obtained
- Beneficiary may be either self represented or represented by an authorized third party such as legal counsel, relative, friend or any other person.

The following procedures shall be followed by Children's County and Organizational providers when issuing an NOA-A:

1. The Notice of Action-Assessment (NOA-A) form shall be issued to a Medi-Cal beneficiary following a mental health screening and/or assessment (face to face or phone) when it is determined by the provider that the beneficiary does not meet medical necessity criteria, resulting in denial of all specialty mental health services.
    a. If upon screening/assessment, the beneficiary is identified as currently receiving specialty mental health services, an NOA-A shall not be issued.
    b. As part of the screening/assessment process, the beneficiary may be informed of the option to obtain care outside the Mental Health Plan. When a beneficiary verbalizes interest only in information gathering or in obtaining a referral outside of the Mental Health Plan (thus declining or modifying the original inquiry for specialty mental health services), no NOA-A needs to be issued. Services outside of the Mental Health Plan may not be reimbursable by Medi-Cal.
2. The NOA-A shall outline the action taken by the Mental Health Plan (MHP) or provider, reason for the action, beneficiary's rights, and citation of the specific regulations or MHP payment authorization procedures supporting the action.
3. In accordance with federal regulations, the NOA-A may be hand delivered on the date of the notice or deposited with the United States Postal Service in time for pick-up no later than three (3) working days of the decision by the provider.
4. All above cited programs shall maintain a Notice of Action Assessment Log on the program site.
5. The NOA-A Log shall document all NOA-As provided to Medi-Cal beneficiaries and their response to the NOA-A, if known.
6. The NOA-A Log shall contain the following information:
    a. Date the NOA-A was issued
    b. Beneficiary identification number, if known
    c. Response, including requests and provisions for second opinions, initiation of grievance/appeal procedure, and/or request for State Fair Hearing, if known.
7. The original NOA-A Log will be maintained at the program site, with a copy of each NOA-A issued attached. When no NOA-As are issued in a given month, the Log shall reflect this information with a check in the appropriate box. The Monthly Status Report shall identify the number of NOA-As issued during the report period.
8. When an NOA-A is issued, the Log shall be submitted with the provider's Monthly Status Report.

Notice of Action (NOA-B)

In response to a provider's request for continued treatment authorization, if the MHP or its designee should determine that a Medi-Cal client's treatment be denied or reduced, the provider and the client will receive an NOA-B form. The NOA-Back form describes the Medi-Cal client's right to file a grievance/appeal, and the right to a State Fair Hearing. Please review the NOA-B with the client and request that he/she sign the form, and return the signed NOA-B to the

point of authorization. The original NOA-B shall be maintained in a confidential location at the program site for a minimum of three years.

If the Medi-Cal client chooses to exercise the right to file an appeal, or request a State Fair Hearing, the appropriate State office to contact is given on the NOA-Back form.

Note: A copy of the NOA-A, NOA-A Log, NOA-B and the NOA-Back forms are included in *Appendix F* (A.F.2, A.F.3, A.F.4) and may be copied.

Additional Types of Notices of Action

In response to 42 CFR, Notices of Action must be sent out for two additional reasons:

1. A Notice of Action form will be sent to a client from an advocacy organization (CCHEA or JFS Patient Advocacy) or the MHP, as appropriate, if a grievance, appeal, or expedited appeal is not completed in accordance with federal timelines. (NOA-E)

2. A Notice of Action form will be sent to a client from OptumHealth if a Treatment Authorization Request (TAR) has been denied as a result of insufficient information submitted by the provider. (NOA-C)

It is expected that issuing these types of NOAs will be infrequent, but may result in clients approaching providers with a few questions. The State has provided the counties with specific forms for these new NOAs.

G. QUALITY IMPROVEMENT PROGRAM

The MHP's philosophy is that high quality mental health care is client-centered, clinically effective, accessible, integrated, outcome-driven, and culturally competent. The purpose of the MHP Quality Improvement Program is to ensure that all clients **regardless of funding source** receive mental health care in accordance with these principles. Each program in the system is expected to have internal quality improvement controls and activities in addition to those provided by the MHP. These activities may involve peer review, program manager monitoring of charts and billing activity, and/or a formal Quality Improvement department which offers training and technical assistance to program staff. Internal monitoring and auditing are to include the provision of prompt responses to detected problems. In addition, all provider programs are required to send a representative to monthly Program Manager meetings, quarterly Leadership Plus meetings, other behavioral health meetings as required, documentation training, and other trainings. Attendance at these meetings is essential to keep abreast of system changes and requirements as part of our continuous improvement efforts.

The quality of the MHP's care and service delivery system is ensured by continually evaluating important aspects of care and service, using reliable, consistent, and valid measurements, with the goal of maximizing each program's effectiveness. The basis of this evaluation process rests in State and Federal legislation and regulations including:

- 42 CFR, Title 9, Chapter 11, of the California Code of Regulations
- State Department of Mental Health (DMH) Letters and Notices
- the MHP Managed Care contract with the State DMH
- the Annual State DMH Protocol

The evaluation process is also being reformulated and expanded to meet a number of new Federal regulations and legislative mandates including the following:

- Mental Health Services Act (MHSA)
- MHSA System Transformational Goals for the County of San Diego
- State mandated Performance Improvement Projects (PIP)

Through program monitoring, program strengths and deficiencies are identified and educational and other approaches are utilized to achieve positive change. To be maximally effective, the Quality Improvement Program must be a team effort. It requires the dedicated effort, responsibility, and involvement of clients, family members, clinicians, para-professionals, mental health advocates, and other stakeholders to share information on strengths and weaknesses of services.

Indicators of care and service, currently being evaluated, include, but are not limited to, client satisfaction, effectiveness of the service delivery system, performance and treatment outcomes,

accessibility of services, cultural competency, adherence to health and safety standards, and preservation of client rights.

CLIENT AND PROVIDER SATISFACTION

The MHP is committed to assessing client satisfaction with the quality of care and provision of mental health services. A satisfaction survey is conducted annually within all organizational programs (excluding detention programs, medication only cases, inpatient and crisis services) as required by the County to assess client satisfaction. The MHP provides education and training to providers regarding the survey, its development, utilization and implementation. See Section N for more information.

Organizational providers are also encouraged to provide feedback regarding their interaction with the MHP by direct communication with the Program Monitor/COTR and MH Contract Administration Unit. Communication can occur at the contractor's request, at periodic, scheduled meetings, and through the monthly status report narrative.

MONITORING THE SERVICE DELIVERY SYSTEM

The MHP mandates internal and external site and clinical monitoring of providers to ensure that all clients receive the highest quality clinical care at the most appropriate level of service. The Quality Improvement Unit conducts program site and chart reviews of both Medi-Cal and Non Medi-Cal clients. Site visits and chart reviews are scheduled a minimum of two (2) weeks in advance, and, as applicable, a copy of the site and clinical record review tool is distributed to the provider at that time. Upon receipt of the records list to review, no revisions shall be made to the clinical record or submitted claims.

Using the Uniform Medical Record

All programs are required to utilize the forms specified in the San Diego County Children's Mental Health Services Documentation and Uniform Clinical Record Manual, and any updated forms, which are issued on an interim basis. The standards for documentation shall be consistent across all clinical programs, regardless of funding source. Programs may adapt forms for specific program needs upon review and approval by the Quality Improvement Unit. The Medical Record for each client must be maintained in a secure location, must be filed in the prescribed order, and must be retrievable for County, State, or federal audit upon request, during and after the provision of services up to the limits prescribed in California law. Each legal entity shall develop forms for legal consents and other compliance related issues. **Out of county** mental health programs may utilize non-San Diego County medical record forms, but they must be in compliance with all State and Federal and requested County guidelines.

County providers are to retain a medical record for 10 years after the discharge date of adult clients, or until a minor has reached the age of 19, but in no case less than 10 years. Organizational providers are to develop their own standard which follows all applicable

guidelines/laws or adopt the county's. County providers are required to retain all Billing Records for a minimum of 5 years in the office, and 2 years off site (for a minimum total of 7 years) when the program is funded with State or Federal dollars. Organizational providers may seek their own legal counsel, adopt the County standard or set an internal standard which follows all applicable guidelines, which include, but are not limited to California Code of Regulations Title 22.

Documentation and in-service trainings are offered by QI to keep providers informed of the latest County, State and Federal standards. The Uniform Clinical Record Manual can be obtained by calling the QI Unit at (619) 584-5026.

Standards for "Late Entry" Documentation

All services provided to a client shall be documented into the client's medical record within a timely manner. Documentation should occur on the date the service was provided. If, however, this documentation does not occur on the date of service, the following shall apply:

- A "late entry" is defined as any documentation that is done on a calendar day other than the date the service was provided.
- When documenting a late entry in the client's medical record, "late entry" should be written at the beginning of the note.
- Late entry notes should be filed in the medical record chronologically to when written, not filed by the date the service was provided.

Claiming for a Late Entry

- Late entries will be accepted for claiming purposes up to 14 days after the date of service.
- If a late entry has not been documented within 14 days from the date of service, the service must still be documented but may not be claimed. The late entry would be considered a non-billable service and would be entered into Anasazi using service code 60.
- A recoupment will be made for a late entry with a documentation date of over 14 days from the date of service if this late entry has been claimed and the claim is included within the audit period of a medical record review.

Meeting Quality Management & Short-Doyle/Medi-Cal Requirements

Programs will be monitored for quality management and compliance with regulations by CMHS Quality Improvement Unit. Programs shall be required to submit and implement a QI Plan of Improvement/Correction for issues/problems identified by the QI Unit. The deadline for any quality improvement plan shall set by the QI Unit based on the individual provider's situation.

Plans of Correction

QI Plan of Improvement/ Correction

The QI Unit monitors organizational and County providers on a regular and annual basis to evaluate the provider's performance in various delegated activities. Medical record reviews are conducted to ensure that MHP contract requirements are met pertaining to documentation standards. Site certification and recertification reviews are also conducted to ensure that all MHP onsite requirements are being adhered to by the provider. If the provider's performance is found to be inadequate, or areas for improvement are identified, a request for QI Plan of Improvement/ Correction will be issued by the MHP to the provider. The provider will have 30 days, or another identified time frame, after receipt of the MHP's written report of findings to complete and submit the specified QI Plan to the QI Unit. The QI Plan must describe the interventions or processes that the provider will implement to address items that have been identified out of compliance or that were identified as needing improvement. In some instances, the QI Unit will be making more specific process improvement recommendations to the provider that must be included in the Plan of Improvement/Correction . When appropriate, the Plan must include all supporting documentation (i.e. copy of a policy and procedure that has been written, description of a system that program is implementing, copy of sign-in sheets from a training, etc.). Even when supporting documentation is not requested to be submitted with the Plan, the program is still required to keep this documentation on-file at their program. The Plan of Improvement/Correction must also include identified timelines and/or dates as to when the out of compliance item or area needing improvement will be implemented or completed. Pursuant to the "Withholding of Payment" clause of the contract, failure to respond adequately and in a timely manner to a request for a POC may result in withholding of payment on claims for non-compliance.

Upon receipt of a Plan of Improvement/Correction, the QI Unit will review what has been submitted to ensure that it adequately addresses the identified items. If the determination is made that the Plan does not adequately address these items, the QI Unit will request that an addendum to the Plan be submitted within a specified time frame.

Programs will be monitored for trends and patterns in any areas found out of compliance or areas needing improvement. Additional QI reviews may occur if a program has an inordinately large number of variances, certain trends and patterns are noted, or is largely out of compliance with standards or contract requirements. These determinations will be made under the direction of the QI Program Manager and may take place within 30 days, 60 days or some other identified time frame depending upon the severity of the noncompliance. For medical record reviews, these additional reviews will include the billing audit and will be subject to recoupment.

When a program's identified trends and patterns for out of compliance items or areas needing improvement are not responding to the program's written Plan of Improvement/Correction, QI may request that the Program COTR issue a Corrective Action Notice (CAN) to the program's Legal Entity. The CAN, given to the Legal Entity, will include a description of the noncompliance categories, history of program's Plan of Improvement/Correction actions, and a statement about insufficient improvement having been made. QI may recommend identified interventions or process changes to be implemented. If a Corrective Action Notice is issued to a Legal Entity, additional County Departments become involved in monitoring remedial activities. Failure to respond adequately and in a timely manner to a required Corrective Action Notice may result in a withholding of payment on the claims for non compliance and could result in putting the contract at risk.

Medical Record Reviews

The MHP mandates site and medical record monitoring of providers to ensure that all clients receive the highest quality clinical care at the most appropriate levels of service. The Quality Improvement Unit conducts program site and medical record reviews. Site visits and medical record reviews are scheduled and coordinated with the Program Manager at each provider site. A copy of the site and medical record review tool is distributed to the Program Manager prior to the scheduled review.

During the medical record review, a Quality Improvement Specialist will review clinical records for:

- Assessment/Appropriateness of Treatment
- Medical Necessity
- Clinical Quality
- Client Treatment Plan and Client Involvement
- Compliance with Medi-Cal, State, Federal, and County Documentation Standards
- Billing Compliance
- Medication Treatment/Medical Care Coordination
- Administrative/Legal Compliance
- Care Coordination
- Discharge

In addition, the QI specialist will conduct a review of the medication service at each program site. This item has been added to the Medical Record Review as QI will stop doing an annual Site Review as of 1/01/2011.

Invalid Services – Void or Replace

In order to maintain a complete audit trail, services entered in Anasazi cannot be deleted. Program must file for void or replacement when billing errors occur. Definitions for Void and Replace are:

Replacement: A replacement is an action taken to address a service that was entered incorrectly, for example typographical errors. To replace a claim the billing provider EIN and Subscriber CIN must be the same between the original claim and the replacement claim, and at least two of the following four elements must be the same:

- Procedure Code
- Place of Service
- Date of Service
- Provider ID
- Void

Void: A void is an action taken to address a service that is not Medi-Cal billable that is being disallowed because the documentation does not meet the standards of billing for that service. SDCBH utilizes the standard State criteria to determine which services do not meet the criteria to be billed and must be voided. Services must have been already claimed and paid by the State before a service can be voided.
Deletion: A deletion is a request to remove a non-Medi-Cal service that has been disallowed because of a provider's review, and the service does not qualify as a valid service.

PROCEDURE(S):

1. Providers are required to conduct internal reviews of medical records on a regular basis in order to ensure that service documentation meets all County, State and Federal standards, and that all Medi-Cal billing is substantiated.
2. If the clinical documentation does not meet the documentation standards as set forth in the current California State Department of Mental Health "Reasons for Recoupment" the provider shall be responsible for addressing the issue by filing a Voided Service request form with SDCBH.
    a. For clients who are not Medi-Cal and documentation does not meet the documentation standards as set forth in the Uniform Clinical Record Manual, a separate process is being developed at this time. Providers should not include non-Medi-Cal clients on the Void or Replacement form. Non Medi-Cal services should be submitted as a deletion on the old Self Report billing form.
3. To file a Void or Replacement form with SDCBH providers shall fill out the Void or Replacement Request form and e-mail the form toe Behavioral Health Administration, Financial Management Unit (FMU). The e-mail address is on the form.

4. **All services that are voided will be identified as such and the units removed from the Medi-Cal and the Total units. These are automatically repaid to the State once the billing unit submits the voided request.** Providers are responsible for re-entering the non-billable services for services that are identified as a Medi-Cal billing disallowance and is voided based on the Void Reason in Attachment A. Corrected service information may only be entered once the provider has confirmed that the incorrect service has been voided. NOTE: Replacements can only be processed by the billing unit, and is only used to correct a data entry error, not for billing disallowance.
5. Providers shall ensure that the services listed on the voided request form as disallowances are noted correctly and do not contain errors. Items that are listed on the form incorrectly are the responsibility of the provider to correct. All disallowed services listed must be listed on the form exactly as they were billed.
6. In order to remove billing from EPSDT Review, providers must send the void request form prior to receipt of notification that an EPSDT Review has been scheduled for that provider. Items received fewer than 21 calendar days prior to the receipt of notification that an EPSDT Review as been scheduled may not be fully processed and therefore may not be removed from the EPSDT Review and may still be subject to recoupment by the State.

Medical Record Claims Review and Provider Self Report of Disallowances

As part of the coordination process for a medical record review with the program, the QI Specialist will notify the program manager of the designated audit period for the billing claims review. The designated billing review period will include the month, date, year that the billing review begins and ends. All billings for the designated period will be reviewed on those medical records that are selected for review. Once the program manager has been informed of the designated billing claims period, no provider self reports of disallowances will be processed for the program that fall within the billing period until completion of the medical record review and resulting final written report by the QI Specialist. At the conclusion of each medical record review, the QI Specialist will present preliminary findings of the review at an on-site exit conference.

For additional record reviews that are conducted by entities other than the MHP (i.e. Department of Mental Health as part of the Mental Health Plan's compliance review or for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) medical record reviews) the same standard will apply. Once the program or legal entity has been notified of an upcoming medical record review and the billing period has been designated, no provider self report of disallowances will be processed for any of the designated program's medical records until completion of the review and receipt of the final report.

Staff Signature Logs

All organizational providers are required to maintain an accurate and current staff signature log that includes all staff that document within the program's clinical records. The MHP requires that this staff signature log include the following elements for each staff person:

- Typed name
- Signature
- Degree and/or licensure
- Job title
- Language capability, if applicable

It is very important that the signature on the log be readily identifiable to the staff person's signature as it appears within the medical record. A staff log signature that is not readily identifiable to the staff's signature within the medical record could place the service provided at risk of disallowance.

To ensure that the log is kept current, it is the organizational provider's responsibility to update and maintain the log in a timely manner to reflect any changes, i.e. licensure, degree, job title, name, or signature. The staff signature log must be maintained onsite at the organizational provider's program location, and be made available at the request of the MHP for purposes of site visits, medical record reviews, etc. Failure to maintain a staff signature log that is accurate and current will result in a plan of corrective action being issued to the organizational provider.

Medi-Cal Recoupment and Appeals Process

It shall be the policy (Recoupment Based on Medical Record Review; No: 01-01-125) of County of San Diego Mental Health Services to disallow billing by Organizational, County, Individual and Group providers that do not meet the documentation standards set forth in the Uniform Clinical Record Manual and to recoup Federal Financial Participation (FFP) in accordance with the current *California State Department of Mental Health Reasons for Recoupment of Federal Financial Participation Dollars, Non-Hospital Services* (*see Appendix J*).
Per the current California State DMH Reasons for Recoupment of FFP Dollars, MHS is obligated to disallow the Medi-Cal claim under the following categories:

- Medical Necessity
- Client Plan
- Progress Notes

Located in *Appendix G, G.1* is the complete listing of recoupment criteria based on the above categories. Organizational and County providers shall be responsible for ensuring that all medical records comply with Federal, State and County documentation standards when billing for reimbursement of services.

At the conclusion of each medical record review, the provider will receive a Medi-Cal Recoupment Summary listing all disallowed billings based on the DMH reasons for recoupment criteria. If the provider disagrees with a Medi-Cal recoupment, QI has developed a 2-level process for a provider who wishes to appeal a Medi-Cal recoupment decision. Providers must submit their appeals in writing to the QI Unit within required timelines. Located in *Appendix G, G.2* is the complete description of the step-by-step appeal process with timelines for first and second level appeals.

Site Reviews

The Quality Improvement Unit is also responsible for monitoring the health and safety of organizational provider sites. Providers must be in compliance with all Federal and State regulatory requirements and MHP contract requirements with DMH. Site reviews are conducted to ensure that providers comply with necessary licenses/certification requirements, maintain a safe facility, and store and dispense medications in compliance with all pertinent Federal and State standards. During the site review visit, a Quality Improvement Specialist may review:

- Physical Plant/facility
- Health and Safety Requirements
- Licenses and Permits
- Required Program Documents
- Personnel
- Medication Service
- Cultural Competence
- Consumer Orientation
- Staff Training & Education
- Client Rights, Grievance & Appeals Process, and Advance Directives
- Staff knowledge of current Organizational Provider Operations Handbook

QI Site Reviews will not be conducted annually as of 1/01/2011, however QI may conduct a site Review of programs on an ad hoc basis to ensure that programs remain in compliance with State Standards. However, the review of Medication Service will continue to be completed annually and will be conducted by QI staff during the Medical Record Review process.

Medi-Cal Certification and Recertification

Contracted and County providers shall be familiar with the Short-Doyle/Medi-Cal delivery system and shall become Medi-Cal certified prior to commencing services and billing Medi-Cal. Providers who bill for Medi-Cal services will be recertified every three (3) years. The re-certification review will include review of the following:

- Compliance with all pertinent State and Federal standards and requirements
- Maintenance of current licenses, permits, notices and certifications as required
- Policies & Procedures or process
- Compliance with the standards established in the Mental Health Services Quality Improvement Plan
- Physical plant/facility requirements
- Adherence to requirements for ensuring the confidentiality and safety of client records
- Medication service
- Adherence to health and safety requirements
- Fire Clearance Requirements for Short-Doyle Medi-Cal Programs

  As part of the Short-Doyle Medi-Cal Certification process for new programs or Recertification of Short-Doyle Medi-Cal programs, the organizational provider will:

  - Secure a new fire clearance document from their local fire code authority and submit a copy to the San Diego County Mental Health Service's Quality Improvement Unit.
  - After receipt of the fire clearance document a site visit will be scheduled. Note: All fire clearance documents must be kept at the program site and be available to reviewers.

  Upon a Short-Doyle Recertification visit (every 3 years) of a current operating site, the organizational provider must make available to the reviewer the most recent site fire clearance document and all previous fire clearance documents. Providers will be in compliance if the most recent fire clearance document has been completed within three (3) years of the previous fire clearance document date. If the most recent fire clearance document has not been completed within the three (3) year period or fire clearance document (s) are not found, the program will receive a Plan of Correction (POC) requesting the appropriate action (s) to be taken by the provider. The action (s) will be included in the POC and sent to San Diego County Mental Health Service's QI Unit to review.

  For any questions on this process please contact Ian B. Rosengarten, QI Specialist at 619-563-2777 or e-mail at ian.rosengarten@sdcounty.ca.gov.

Medication Monitoring

State and County CMHS regulations require all organizational providers with programs prescribing medication in the course of their services to have a medication monitoring system. Out of County Providers shall adhere to their own County's Medication Monitoring process. Current State Department of Mental Health (DMH) requirements for Medication Monitoring (MM) are set forth in CCR, Title 9, Chapter 11, Section 1810.440; MHP Contract with DMH, Exhibit A, Attachment 1, Appendix A, B.4. The primary purpose of medication monitoring is to ensure the most effective treatment. Areas monitored include:

- Medication rationale and dosage consistent with community standards
- Appropriate labs prescribed
- Consideration of physical health conditions
- Effectiveness of medication(s) prescribed
- Adverse drug reactions and/or side effects
- Evidence of signed informed consent
- Client adherence with prescribed medication and usage
- Client medication education and his/her degree of knowledge regarding management of medications.

Within the MHP system, open records of medication services for all County-operated and contracted programs are sampled on a 5% per annual basis.

Contracted providers are required to perform the first-level screening of medication monitoring for their facility, using the Medication Monitoring Screening Tool. If a variance is found in medication practices, a Medication Monitoring Feedback Loop (McFloop) form is completed, given to the psychiatrist for action, and then returned to the Medication Monitoring Committee for approval. Results of medication monitoring activities are reported quarterly by the 15th of each month following the end of each quarter to the QI Unit using the Medication Monitoring Submission Form (this form can be emailed). Any McFloop forms that have been disapproved shall be sent (via fax or hard copy mail) to the QI Unit within 30 days of the reporting deadline for each quarter. Completed medication monitoring tools and medication monitoring minutes shall be kept on file by contracted providers. Programs will be asked to provide evidence of their medication monitoring practices during their Medical Record Review or Site Visit. *(The Medication Monitoring Screening Tool (A.G.3), Committee Minutes form (A.G.4, McFloop form (A.G.5) and Medication Monitoring Submission Form (A.G.13) are located in Appendix G.)*

The Health and Human Services Agency Pharmacy is responsible for performing the medication monitoring for County-operated facilities. The Chief of Pharmacy submits a written quarterly report that includes results of screening and clinical review activities to the clinic program managers and the Mental Health Quality Improvement Unit.

The QI Unit evaluates the reports from both the contractors and Chief of Pharmacy for trends, compiling a summary report submitted to the Quality Review Council (QRC), Program Monitor/COTR, and the Pharmacy and Therapeutics Standards and Oversight Committee (P&T) quarterly. If a problematic trend is noted, the report is forwarded to the Medical Director for recommendations for remediation.

Storage, Assisting with Self Administration, and Disposal of Medications

Only authorized California licensed personnel within the scope of their practice and in accordance with all Federal laws and regulations governing such acts shall administer medications. These licensed personnel include; physicians, physician assistants, nurse practitioners, registered nurses, licensed vocational nurses and licensed psychiatric technicians.
In instances where clients must take medications during the provision of mental health services, and licensed personnel are not present, the following procedures shall be in place:

1) Storage of Medications

a) The client's parent/guardian shall bring in the prescribed medication which is packaged and labeled in compliance with State and Federal laws.

b) Medications shall be logged in on the " **Perpetual Inventory Medication Log**" (See *Appendix G, G.6*)

c) All medications shall be stored in a locked, controlled and secure storage area. Access to the storage area shall be limited to authorized personnel only.

d) The storage area shall be orderly, well lit and sanitary. It shall have the proper temperature, light, moisture, ventilation and segregation that is required by Federal, State and County laws, rules and regulations.

e) All controlled substances shall be double locked for security and shall only be accessible to authorized personnel.

2) Assisting in the Self Administration

a) Careful staff supervision of the self administration process is essential. Program staff shall provide the individual dose from the packaged and labeled container for client to self administer.

b) Staff shall record the self administration of all medications on the **Perpetual Inventory Medication Log**.

3) Disposal of Medications

a) Disposal shall occur when the medications are expired, contaminated, deteriorated, unused, abandoned, or unidentifiable. Programs may return medications to pharmacy representatives for disposal, or dispose of medications by placing them in biohazard sharps containers for transportation to incineration. If neither of these methods is available, the program can contact a pharmaceutical disposal company for transport

and disposal. Examples include: Stericycle 1 (866) 783-7422 and KEM (619) 409-9292. Disposal by flushing medications into the water system or placing in the trash are both prohibited under environmental and safety regulations.

b) Disposal shall be documented and co-signed on "**Medication Disposal Log"** (*Appendix G. G.7*).

ACCESSIBILITY OF SERVICES

The provider is responsible for preparing and maintaining appropriate records on all clients receiving services in compliance with CCR, Title 9, Chapter 11 and 42 CFR guidelines. This includes on site and secure maintenance of a written Request for Services Log. At a minimum, the log must contain the name of the individual, the date of the request, the nature of the request, the initial disposition of the request, and whether the request was routine, urgent or an emergency. County and Organizational providers are to retain log for a minimum of 5 years in the office, and 2 years off site (for a minimum total of 7 years).

The provider is expected to meet the MHP standards for access to emergency, urgent and routine mental health services to ensure that clients receive care in a timely manner. These access standards refer to the acceptable timelines for triage, intake, assessment, and clinical evaluation.

Wait Times

Another measure of system efficiency is the amount of time that clients need to wait to receive services. County operated and designated County contracted organizational providers of outpatient assessments and medication evaluations report Wait Time information each month to CMHS. This information shall be reported on the Monthly Status Report to the Program Monitor/COTR, the Contract Administration Unit, and other designated staff. The procedure for calculating and reporting wait times shall be as specified by CMHS. The standard for outpatient waiting time is an average of 5 days or less across the system, and no more than 30 days per individual client. If a client is unwilling to wait as long as necessary in a given program, the program must refer to another provider (including emergency rooms, if needed) who can offer a more timely appointment. Requests for services must be logged on the Request for Services Log. (*Appendix C. C.1.)* The Wait Time (for both Mental Health and Psychiatric Assessments) is defined as the time between the initial contact from a new client requesting services until the first *available* appointment.

Wait Time benchmarks have been established for each outpatient program based on historical data. Wait Times are monitored by CMHS, and any program that consistently exceeds its Wait Time benchmark will be required to submit a quality improvement plan.

Wait Times for Emergency and Urgent Services:

- Any client who needs emergency service shall have his/her needs addressed within one hour.

- Any client who meets the criteria for needing "urgent" services shall be seen within 72 hours. Any client being discharged from a psychiatric hospital facility, or who calls for services and is screened as needing services urgently meets the "urgent" criteria and shall be seen with 72 hours.

CLIENT AND PERFORMANCE OUTCOMES

In April of 2004, the Mental Health Board adopted new outcome measures for Children's Mental Health programs. These measures include the Child and Adolescent Measurement System (CAMS) and the Family Centered Behavior Scale (FCBS). The outcome tools measure the effectiveness and appropriateness of County funded Children's Mental Health programs. In March of 2005 a Client Functioning Quadrant measure rating 8 domains was implemented, and in August of 2007 it was replaced by the Colorado Functional Assessment Rating Scale (CFARS) which consists of a 16 index rating. Section N details the system-wide outcome measures for CMHS. Additional performance requirements are described in that section.

Some data is obtained via the Anasazi system. Other data is manually collected by providers and submitted in the Monthly Status Report. The data is useful in determining trends and patterns in service provision and demand, as well as identifying opportunities for improvement.

Monthly Status Report (MSR)

Providers are required to submit a monthly status report to the COTR which gives the MHP vital information about provider services. All sections of the report must be completed. Instead of twice yearly reports on staffing for cultural competence, the new form includes a place to report monthly on staffing and training. This report form is updated periodically in accordance with changing State, Federal and County regulations. A current sample of the MSR form is included in *Appendix G. G.8.*

Client Outcomes

In conjunction with new State and Federal mandates to show program effectiveness and client progress, the MHP is extending the Client Outcomes tracking to all programs. See section N – Data Requirements and Section A – Systems of Care for client outcomes indicators determined by the MHP.

Participating programs shall report their outcomes data on the *Monthly Status Report* according to defined timelines. The Program Monitor/COTR will review the results, check for adherence to the outcome standard, and identify if a plan of correction is needed. The QI unit will track trends for the data provided on the MSR. The specific outcomes procedures by level of care, the outcomes tools, and reporting requirements can be obtained by contacting your Program Monitor/COTR and/or Child and Adolescent Research Center (CASRC).

Mental Health Services Act (MHSA) Outcomes

Under the MHSA in San Diego, new programs are being started while others are expanding. As the MHSA is implemented across the State, new requirements for outcome reporting are anticipated to document how these funds are changing the lives of mental health clients. Providers receiving MHSA funding will be responsible for complying with any new requirements for additional outcome data. Currently, programs that have entered into Full Service Partnerships under the MHSA are required to participate in a direct State data collection program which tracks initial specialized client assessments, ongoing key incident tracking, and quarterly assessments.

Performance Improvement Projects (PIPs)

The State has mandated that each county be engaged in one administrative and one clinical performance improvement project each year in order to improve processes and outcomes of care. A PIP is a comprehensive, long-term study which includes a commitment to improving quality through problem identification, evaluating interventions and making adjustments as necessary. It may provide support/evidence for implementing protocols for "Best Practices". Progress on each PIP is evaluated annually by the External Quality Review Organization (EQRO), an independent State contracted organization.

The MHP may ask for your involvement in the PIP by:

- Implementing current PIP interventions/activities/procedures at your programs
- Supporting survey administration and/or focus group coordination at your programs
- Developing your own program's PIP projects

Incident Reporting

An incident that may indicate potential risk/exposure for the County – operated or contracted provider (per Statement of Work), client or community must be reported to the County. There are two types of reportable incidents. Serious Incidents are reported to the MHS Quality Improvement Unit. Unusual Occurrences are reported to the program's COTR.

Serious Incident Reporting To Quality Improvement Unit

All providers are required to report serious incidents involving clients in active treatment or whose discharge from services has been 30 days or less. Required reports shall be sent to the MHS Quality Improvement Unit who will review, investigate as necessary, and monitor trends.

The MHS Quality Improvement Team will communicate with program COTRs and MHS management staff as needed on all reported serious incidents. The provider shall also be responsible for reporting serious incidents to the appropriate authorities.

Serious incidents are categorized as follows:

- ▲ Death, excluding natural cause, includes death by suicide
- Homicide by a client - attempted homicide by a client
- Suicide attempt resulting in severe physical damage and/or loss of consciousness, respiratory and/or circulatory difficulties requiring medical attention
- For mental health clients: use of physical restraints (prone or supine) *****
- Adverse medication reaction resulting in severe physical damage and/or loss of consciousness; respiratory and/or circulatory difficulties requiring hospitalization
- Medication error in prescription or distribution resulting in severe physical damage and/or loss of consciousness; respiratory and/or circulatory difficulties requiring hospitalization
- Serious physical injury resulting in a client experiencing severe physical damage and/or loss of consciousness; respiratory and/or circulatory difficulties requiring hospitalization
- Injurious assault on a client or by a client occurring on the program's premises resulting in severe physical damage and/or loss of consciousness; respiratory and/or circulatory difficulties requiring hospitalization
- Inappropriate staff behavior such as sexual relations with a client, financial exploitation of a client, and/or physical or verbal abuse of a client
- ▲ Major confidentiality breach (lost or stolen laptop, large number of client files/records accessed, etc.)

*****Excluding Hospitals, Long-Term Care Facilities, San Diego County Psychiatric Hospital/EPU, and PERT

Please Note:

For the Serious Incidents identified with a ▲ above, the Serious Incident Report of Findings must include a confirmation that an in-depth analysis of factors contributing to the event has been completed. The Serious Incident Root Cause Analysis Worksheet found in Appendix G (A.G.11) is required for San Diego County operated programs per current HHSA/MHS

General Administration Policies and Procedure for all incidents noted with a ▲. San Diego County Contracted programs may use the Serious Incident Root Cause Analysis Worksheet or some other process that is approved by their Legal Entity. It is strongly recommended that programs choosing not to use the Serious Incident Root Cause Analysis Worksheet ensure that the process they do use incorporates best practices for their analysis of findings (see http://www.jointcommission.org/sentinelevents/forms/ for more info on RCA). Based on the results of the analysis the report of findings should describe what plans the program has for correcting those systemic factors that contributed to the event. Technical Assistance to complete the Serious Incident Root Cause Analysis Worksheet is available through the MHS QI Unit by calling QI at 619-563-2747. Training on completing the RCA will be offered.

Level 1 or 2 Serious Incident

Serious incidents shall be classified into two levels with Level One being most severe and Level Two less severe. A Level One incident must include at least one of the following:

- The event is associated with a significant adverse deviation from the usual process for providing mental health care.
- The event has results in a death or serious physical injury on the program's premises.
- The event has the potential for significant adverse media involvement.

For a Level One incident, the provider shall telephonically notify the County Quality Improvement Unit at 619-563-2781 as soon as possible but no later than within 24 hours. The provider shall also complete a Serious Incident Report (see *Appendix A.G.9*) and fax it to the QI Unit within 72 hours.

For a Level Two incident, the provider shall telephonically notify the County QI Unit at 619-563-2781 within 24 hours and fax a Serious Incident Report *(Appendix A.G.9)* to the QI Unit within 72 hours.

Within 30 days of submitting a Serious Incident Report, the provider shall submit a Serious Incident Report of Findings (*Appendix A.G.10*) by mail or fax, summarizing the findings, identifying interventions, outcomes, and/or other improvements implemented as a result of the incident.

After review of the incident, the MHP may order a corrective action plan. The MHP is responsible for working with the provider to specify and monitor the recommended corrective action plan.

The MHS QI Unit will monitor trends of Serious Incident Reports and report to the QRC and Mental Health Administration Executive Team periodically and as required resolving any problematic issues.

Level One Serious Incident Reporting on Weekends and Holidays

Level One Serious Incidents are required reporting for Legal Entity (LE) mental health programs on weekends and holidays to the QI Unit and Designated County Staff.

Please follow this procedure for reporting a **Level One** Serious Incident on Weekends and Holidays.

1. For a Level One Serious Incident, call the QI Serious Incident Report Line and report the incident as usual.
2. Each LE will identify key Senior Level staffs (1-3) that are designated as the main contact person(s) for their programs needing to report a Level One incident on weekends and holidays. This LE designated staff will report the Level One incident by calling or leaving a message with all required information including a call back number for the County Designated Staff. Each LE will be provided the contact phone numbers of the County Designated Staff.
3. Program staff should only be reporting the Level One Serious Incident to their LE designated staff. Program staff should not be directly contacting the County Designated Staff.
4. Report Level One Serious Incidents to the County Designated Staff on weekends and holidays between the hours of 8:00am – 8:00pm (reporting hours). If you have a Serious Incident that occurs outside of reporting hours, then report the Serious Incident on the next or same day during reporting hours. This requirement is only for Level One Serious Incidents.
5. Weekend Coverage is defined as Saturday and Sunday. Holiday Coverage is defined as any designated County Holiday.

Unusual Occurrence Reporting To COTR

An unusual occurrence is defined as an incident that may indicate potential risk/exposure for the County program, client, or community. Unusual occurrences may include but are not limited to:

- Alleged child abuse
- Police involvement.
- Inappropriate sexual behavior

- Self injury
- Physical abuse
- AWOL
- Fire setting
- Poisoning
- Major accident
- Property destruction
- Epidemic outbreak
- Physical injury
- Loss or theft of medications from facility

Additional Incident Reporting

The following providers who serve the client involved in the Unusual Occurrence and/or Serious Incident shall also be **notified** within 24 hours (or upon the resumption of business hours of the County Office) when Unusual Occurrences and/or Serious Incidents are identified. This includes but is not limited to:

- Mental Health Case Manager
- Children's Services Bureau social worker
- Probation Officer
- Regional Center Case Manager
- Special Education Services (SES) Case Manager
- Therapeutic Behavioral Services (TBS) – Both County and Contractor
- All other Case Management programs that also serve the client

Reportable issues include:

1. A school suspension
2. A student is taken to a hospital due to an injury or other medical issue which occurs at the program site or when the TBS worker is present
3. A referral for acute psychiatric hospital care
4. An issue with direct service provider staff, which may lead to worker suspended or no longer providing services
5. A significant problem arising while TBS worker is with the child

The County Program Monitor/COTR will determine the appropriate method of investigation within thirty (30) business days and notify the Program Director. Depending upon the nature and seriousness of the incident, the County may choose to investigate the incident itself.

Notification to Agencies for Safety and Security Purposes

When Unusual Occurrences occur or are identified, the appropriate agencies will be notified within their specified timeline and format:

1. Children's Services Bureau Hot Line for child abuse reporting and injuries.
2. Intended victim and law enforcement, for Tarasoff reporting.
3. Law enforcement (police, sheriff, school police, agency security, military security/Naval Investigative Service, etc.) for crime reporting or requiring security assistance and inquiries.
4. Every fire or explosion which occurs in or on the premises shall be reported within 24 hours to the local fire authority or in areas not having an organized fire service, to the State Fire Marshall.

Notification by County and Contract Programs

County-operated or contracted Mental Health program providers are required to provide notification to their COTR within 24 hours when any Unusual Occurrences occur.

Quality Review and Improvement Process

County Children's Mental Health Administration shall review and/or report all unusual occurrences and serious incidents that may be potential quality of care concern to the following as required:

- County Counsel
- Patient Right's Advocate
- Center for Consumer Health, Education and Advocacy (CCHEA),
- District Attorney's Office
- Attorney General's Office
- Mental Health Board

QUALITY REVIEW COUNCIL (QRC)

The Quality Review Council (QRC) is a collaborative group that is chaired by the MHP Clinical Director and consists of MHP stakeholders including clients and family members, County and contracted providers, associations and advocacy groups representing the mental health community, and hospital providers. The QRC meets regularly to review, discuss and make recommendations regarding quality improvement issues that affect the delivery of services through the MHP. Participation in the QRC is encouraged. If you would like to participate in the QRC, please contact the QI unit at (619) 563-2778.

H. CULTURAL COMPETENCE

Cultural Competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers, family member providers, and professionals that enables that system, agency or those professionals, consumer, and family member providers to work effectively in cross-cultural situations.

History and Background

Cultural norms, values, beliefs, customs and behaviors may influence the manifestation of mental health problems, the use of appropriate levels of care/services, the course of treatment and the successful attainment of positive outcomes. The County's dynamic demographics combined with the recognition that culture is a key factor in service delivery pose an ongoing challenge for the MHP and its contracted mental health care providers. The 2010 United States Census reports a 10% population increase in San Diego County, with no single racial/ethnic group comprising a majority. Whites make up 48% of the population, Hispanics 32%, Asians 11%, Blacks 5% and Native Americans/American Indians 1%.

As the diversity of the population continues to increase, the 2010 Cultural Competence Plan San Diego County Mental Health noted an increase in the number of Medi-Cal mental health clients from various minority populations. While progress has been made in addressing disparities in service among ethnic and racial populations, the Plan notes that minority populations are still under-represented among total mental health clients, especially among adult populations. For example, as of 2007, 10% of the County population was Asian/Pacific Islander , but only 6% of the adult mental health clients and 2.6% of child clients were from these ethnic groups in FY 09-10. A disparity was also found between the number of minority clients participating in the Medi-Cal program and the number of clinicians available with self-assessed proficiency in needed ethnic, racial and cultural specialties.

The Cultural Competence Plan reports that in addition to changing demographics related to ethnicity and race, age demographics are changing in the county and will affect service demands. The child population is the most rapidly increasing portion of the population. The number of older adults living in San Diego is also growing, with 20% being 55 plus years of age.

Cultural Competence Plan

To address these issues in the 2010 Cultural Competence Plan, the MHP set the following objectives to improve cultural competence in the provision of mental health services:

1) Continue to conduct an ongoing evaluation of the level of cultural competence of the mental health system, based on an analysis of gaps in services that are identified by comparing the target population receiving mental health services to the target population receiving the Medi-Cal and the target population in the County as a whole.

2) Continue to compare the percentage of each target population with provider staffing levels
3) Investigate possible methods to mitigate identified service gaps
4) Enhance cultural competence training system-wide
5) Evaluate the need for linguistically competent services through monitoring usage of interpreter services
6) Evaluate system capability for providing linguistically competent services through monitoring organizational providers and FFS capacities, compared to both threshold and non-threshold language needs
7) Study and address access to care issues for underserved populations.

Current Standards and Requirements

To meet State and County requirements, providers are required to maintain and reflect linguistic and cultural competence through all levels of their organization in their policies, procedures, and practices. Providers must ensure that program staff is representative of, and knowledgeable about, the clients' culturally diverse backgrounds and that programs are reflective of the specific cultural patterns of the service region.

Culturally Competent Clinical Practice Standards:

The Culturally Competent Clinical Practice Standards currently utilized by SDCMHS have the following goals: 1) promote and encourage values and approaches that are necessary for the support and development of culturally competent practices; 2) increase and improve knowledge and understanding of concepts and information critical for the development and implementation of culturally competent practice, and; 3) establish goals for the development/improvement of practice skills of all members in the system to ensure that cultural competence is an integral part of service delivery at all levels.

The standards are as follows:

1) Providers engage in a culturally competent community needs assessment.
2) Providers engage in community outreach to diverse communities based on the needs assessment.
3) Providers create an environment that is welcoming to diverse communities.
4) Staffing at all levels, clinical, clerical, and administrative, shall be representative of the community served.
5) There is linguistic capacity & proficiency to communicate effectively with the population served.
6) Use of interpreter services is appropriate and staff is able to demonstrate ability to work with interpreters as needed.
7) Staff shall demonstrate knowledge of diversity within ethnic and cultural groups in terms of social class, assimilation, and acculturation.

8) Staff shall demonstrate knowledge about a) specific cultural features that may be present in various disorders, b) culture-bound syndromes, c) cultural explanations of illness, d) help seeking behaviors, include faith-based, in diverse populations, and e) appreciation for traditional ethnic and cultural healing practices.

9) Cultural factors are integrated into the clinical interview and assessment.

10) Staff take into consideration the potential bias present in clinical assessment instruments and critically interpret findings within the appropriate cultural, linguistic and life experiences context of the client.

11) Culture-specific consideration consistent with the cultural values and life experiences of the client shall be integral in the intervention and shall be reflected in progress notes, treatment planning and discharge planning.

12) Psychiatrists will consider the role of cultural factors (ethnopsychopharmarcology) in providing medication services.

13) Providers promote an environment that encourages staff to conduct self-assessment as a learning tool.

14) Staffs actively seek out educational, consultative and multicultural experiences, including a minimum of 4 hours of cultural competence training annually.

Culturally Competent Practice Standards are operationalized for mental health providers as follows:

- To support the cultural competence standards, providers are required to maintain policies and procedures that support culturally competent services and provide training to staff.
- Staff should reflect the specific cultural patterns of the region to the maximum extent possible.
- Providers are to recruit staff who can meet the language needs of their clients to the maximum extent possible.
- Include in job applications, questions regarding experience in working with ethnic/minority clients, and/or culture communities for direct service or interpreting positions.
- Establish a method or process for ensuring that staff who indicate they are bi/multi-lingual have the language capability to appropriately communicate ideas, concerns, and rationales.
- Contractor shall ensure that program staff are knowledgeable of the culturally diverse backgrounds of the clients being served by the program.
- Contractors shall establish a method or process for ensuring that staff who indicate they are bi/multi- cultural have knowledge of culturally appropriate evaluation, diagnosis, treatment, referral resources, and familiarity with culturally variant beliefs regarding mental illness.
- Train direct services staff on MHP Cultural Competence Clinical Practice Standards and establish a process for monitoring adherence to the standards.

Cultural Competence Training Opportunities through the MHP

- Cultural Competence Trainings are available through the County Knowledge Center for County operated program staff at no cost and for a small number of providers on a fee basis.
- Cultural Competence Trainings available through some of SDCMHS's larger contractors. Community Research Foundation, New Alternatives, and Mental Health Systems, Inc offer their own such trainings to their own program staff but other providers may send staff on a fee basis.
- SDCMHS Contracted Trainings through the Behavioral Health Education and Training Academy (BHETA). Limited classroom training and on-line trainings are available at no cost to staff of County contracted and County operated programs.
- SDCMHS Cultural Competence Academy Intensive Training—a 32-40 hour course will be offered starting in Fall, 2011 to two groups of up to 60 staff per year to implement a Cadre model for cultural competence training.
- MHSA Workforce Education and Training Plan Educational Opportunities—includes a Nursing Partnership for Public Mental Health Professions; a Community Psychiatry Fellowship; Child Psychiatry Fellowship; LCSW/MFT Residency /Intern; and Targeted Financial Incentives to Recruit and Retain Licensable and Culturally, Linguistically and/or Ethnically Diverse Public Mental Health Staff. Details on these programs can be obtained from MHSA staff person Liz Miles at Elizabeth.miles@sdcounty.ca.gov.

Cultural Competence Monitoring and Evaluation:

The MHP QI Unit and the COTR are responsible for monitoring and evaluating compliance with cultural competence standards as outlined in the County's Cultural Competence Plan and with State and Federal requirements. The QI Unit and the COTR utilize both the medical record review and the annual Contract Review to monitor providers regarding cultural competence. In addition, provision of/usage of the tools listed below are now cultural competence requirements:

Program Level Requirements:

1. Cultural Competence Plan. By April 1, 2012, contractors are required to provide a Cultural Competence Plan that includes how the contractor will tailor services to reflect the ethnic, racial, cultural and linguistic profile of their service area, as well as plans for addressing and reducing any service disparities affecting the program
    - If your organization has already developed a Cultural Competence Plan, you may submit it any time prior to April 1, 2012.
    - If your organization does not have a Plan, the County will be providing a format that may be used.

- Plans can be sent via email to Allison Williams at Allison.Williams@sdcounty.ca.gov or mailed to:

  Allison Williams
  Cultural Competence Plan
  3255 Camino del Rio South
  San Diego, CA 92108

2. Culturally Competent Program Annual Self-Evaluation (CC-PAS)--Complete annually a cultural competence assessment of each program, using the tool which will be provided by SDCBHS to each program. This survey will be delivered electronically (planned to be in a Survey Monkey format) to the programs in the Winter/Spring of 2011 and must be completed by all programs within one month of distribution. The CC-PAS is a 22 item survey that can be completed in approximately 1 hour or less. For your information, a copy of the CC-PAS has been included in the Organization Provider Handbook, Appendix H.

3. In order to present a welcoming appearance to unique communities, providers are required to ensure that their facility is comfortable and inviting to the area's special cultural and linguistic populations. Program hours of operation must be convenient to accommodate the special needs of the service's diverse populations.

Staffing Level Requirements

4. California Brief Multicultural Competence Scale (CBMCS). Contractors are required to assess at least every other year the cultural competence of all staff members who provide direct services to clients through the use of the California Brief Multicultural Competence Scale (CBMCS) tool. The CBMCS will be delivered electronically (planned to be in a Survey Monkey format) by SDCBHS to programs in the Fall 2011 and must be completed by program staff within one month of distribution. The CBMCS is a 21-item assessment that can be completed in less than 30 minutes. For your information, a copy of the CBMCS has been included in the Organization Provider Handbook, Appendix H. Programs are to maintain copies on file for review.

5. A Minimum of 4 hours of Cultural Competence Training Annually. Contractors shall require that at a minimum, all provider staff, including consultants and support staff interacting with clients or anyone who provides interpreter services, must

participate in at least four (4) hours of cultural competence training per year. Training may include attending lectures, written coursework, review of published articles, web training, viewed videos, or attended a conference can count the amount of time devoted to cultural competence enhancement. A record of annual minimum four hours of training shall be maintained on the Monthly Status Report. The following conditions also apply:

a. All new staff must meet the requirements within 90 days of hire; including temporary staff who have been on site at least 90 days.
b. Staff hired after May 15 are exempt from the requirement for that fiscal year but must meet requirement a.
c. Volunteers who have served or are expected to serve 100 or more hours at the program must meet the requirement.

***Consumer Preference: Cultural/Ethnic Requirements**:*

Consumers must be given an initial choice of the person who will provide specialty mental health services, including the right to use culturally specific providers. Providers are also reminded that whenever feasible and at the request of the beneficiary, clients have the right to request a change of providers. Requests for transfers are to be tracked on the Suggestion and Transfer section attached to the Monthly Status Report.

***Consumer Preference: Language Requirements**:*

Services should be provided in the client's preferred language. Providers are required to inform individuals with limited English proficiency in a language they understand that they have a right to free language assistance services. There shall not be the expectation that family members provide interpreter services, including the use of minor children. A consumer may still choose to use a family member or friend as an interpreter, only after first being informed of the availability of free interpreter services. The offer of interpreter services and the client's response must be documented.

Progress notes shall indicate when services are provided in a language other than English. Providers are also reminded that, whenever feasible and at the request of the beneficiary, consumers must be given an initial choice of or the ability to change the person who will provide specialty mental health services, including the right to use linguistically specific providers.

Some county and contracted programs are Mandated Key Points of Contact. As a Mandated Key Point of Contact, the program must have staff or interpretation available to clients during regular operating hours that are linguistically proficient in the mandated threshold languages. The Access and Crisis Line, the EPU, and the Center for Community Health Education and Advocacy are Mandated Key Points of Entry for all threshold languages. In addition the following clinics are also designated as Mandated Key Points of Entry for the languages listed:

- Spanish

- EPU
- All Outpatient and Case Management programs

• Vietnamese
- UPAC

• Tagalog
- UPAC

• Arabic
- East County Mental Health

All other County and Contracted providers must at a minimum be able to link clients with appropriate services that meet the clients language needs whether the language is a threshold language or not.

Additional Recommended Program Practices

Programs will also be encouraged to do the following:

- If there is no process currently in place, develop a process to evaluate the linguistic competency of staff that is providing service or interpretation during services, in a language other than English. This may be accomplished through a test, supervision or some other reliable method. The process should be documented.

- Conduct a survey or client focus group every couple of years and include clients who are bi-lingual and monolingual to assess program and staff cultural competence, assess community needs and what efforts the program is making to meet those needs. Topics that may be covered in the survey or focus group include:
  - Regarding Language:
    - Offers of providers who speak the client's language, or interpreter services
    - Linguistic proficiency of staff providing services or of interpreter if one is used
    - Staff's ability to clearly communicate ideas, concerns, and rationales in client's preferred language
    - Availability of written materials, including alternate formats in client's preferred language
  - Regarding Culture/Ethnicity:
    - Direct services staff's knowledge of culturally appropriate evaluation, diagnosis, and treatment
    - Direct services staff's knowledge of culturally appropriate referral resources
    - Direct services staff's familiarity with variant beliefs regarding

mental illness

- Appropriateness of clinic environment

• The County will provide technical assistance with developing survey/focus group questions in the Cultural Competence Handbook available in Fall 2011.

• Explore whether there are barriers to service being created by cultural competence issues.

• Document the results of the focus group(s) including findings and plans for interventions, as needed.

I. MANAGEMENT INFORMATION SYSTEM

Anasazi

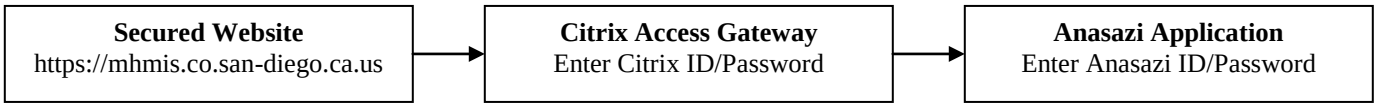
San Diego County Mental Health Services contracted in 2006 with Anasazi Software to create a new Mental Health Management Information System (MH MIS). Previously there was one system for client tracking/billing and one for managed care authorizations. The new MH MIS replaces the two systems with one integrated system. All client information, including clinical documentation, will be entered into this integrated system, thus allowing each staff responsible for a client's care to access that client's pertinent information.

For the complete **Management Information System: Anasazi User Manual**, go to the Optum Public Sector Website at https://www.optumhealthsandiego.com

User Account Setup and Access

The Mental Health Management Information System (MH MIS) is used by County and contract operated programs for client tracking, managed care functions, reporting and billing. An electronic health record (EHR) will replace much of what is contained in the paper medical record. Many controls are built into the software and hardware to safeguard the security and privacy of client personal health information.

MH MIS uses Anasazi Software which is a web based application that is housed on the County of San Diego Network. Network access to County data systems, including MHMIS, is the responsibility the County Technology Office (CTO). Security and maintenance of the County network is outsourced to the County's Information Technology Outsourcing Contractor (ITOC). Under the direction and oversight of the CTO, the ITOC is responsible for the security of the county network, the Citrix Access Gateway and maintenance of the County's servers which host the Anasazi application. In addition, the ITOC is responsible for the set up and maintenance of Citrix user network accounts. The following diagram demonstrates the access to Anasazi through the County network secured internet website using the Citrix Access Gateway.



System Administration responsibility for MH MIS is shared between the Administrative Services Organization (ASO) and the County's Mental Health MIS Unit.

- The Mental Health MIS (MH MIS) Unit is responsible for managing access, security, and menu management in Anasazi in accordance with County, State and Federal HIPAA regulations. The MH MIS Unit is also the gatekeeper who ensures that staff is only given

access pursuant to contract agreements. In addition, the MH MIS Unit is responsible for coordination among the CTO, ITOC and the ASO.

The ASO is responsible for other system administration activities such as table management, system maintenance, updates to the application, managing the five Anasazi environments, producing reports for legal entities, electronic submission of state reporting, coordination with Anasazi Software, and providing the User Support Help Desk.

Technical Requirements to Access Anasazi

Prior to accessing the Anasazi application via the internet, there are some basic technical requirements. For questions about whether an individual user or program site meets the basic technical requirements, it is recommended that the individual or program contact their company's IT department. The ASO may also be able to provide some technical assistance.

In order to access and operate Anasazi the following are required:

- Operating System on computer:
  - Windows 2000 (Citrix 10.0 does not supports Windows 95/98)
  - Windows XP Pro
  - Windows XP Home
  - Windows 2003 Server (if used as a client)
- Internet Explorer version 5.0 or later with a minimum of 24 kbps per concurrent user (high speed internet access)
- A Citrix compatible printer (most newer printers today are Citrix compatible)
- Download Citrix Presentation Server Client file on the user's computer

Staff Set Up and User Account Access

All individuals who provide services or perform some other activity to be recorded in MH MIS as well as those who are authorized to access MH MIS must have a staff account. A "staff" in Anasazi is defined as an individual who is employed, contracted or otherwise authorized by his or her designated legal entity or County business group to operate within the County of San Diego public mental health System of Care and whose primary job function may include any one of the following: to provide Mental Health Services, Quality Assurance activities, enter data, view data, or run reports. This includes clinicians, doctors, nurses, office support staff, financial/billing staff, research/analyst staff and program managers/administrative staff. All staff will be assigned a staff ID, which is a numerical ID ranging from 15 numbers. (**Note:** If a person is employed by more than one legal entity, he/she will have a unique staff ID for each legal entity.)

Staff is given access to specific Unit(s)/SubUnit(s) based upon the program(s) where they work. Staff is also given access to specific menus based on their respective job functions. A list and

definition of menus is available on the Anasazi Request Form. For additional information regarding staff or program access contact the SDCMHS MIS System Administration.

Staff authorized to access MH MIS will be given login access and a password and are considered "users".

User Access requires the following steps:

1. Program manager completes the "Anasazi Request Form" (ARF).

2. Contractor employee must also read and sign the County's "Summary of Policies" (SOP) form. This must also be signed by the employee's supervisor.

3. Fax all completed forms to the **MH MIS Unit Fax at (858) 467-0411.**

4. MHMIS Unit completes the County's "Computer Services Registration Form" (CSRF).

All forms **must** be typed, and contain all necessary information. Incomplete forms will be returned to the contact person listed on the form. Once completed correctly, the forms must be re-faxed to MH MIS Unit. Please ensure forms are completed correctly to avoid delay in user account setup.

Once all forms have been submitted, the MH MIS Unit will:

1. Complete and process the CSRF for set up of a Citrix User Account with ID/password

2. Set up Anasazi User Account with ID/password

3. User will be provided his/her Citrix/Anasazi ID/passwords at the Anasazi training.

Program managers and other supervisors are responsible to:

1. Register new staff who will be users to attend the "New User Anasazi Training"

2. Contact the QI Unit to confirm Anasazi training date/time/location

3. Confirm that employee has successfully completed Anasazi training

Note: No user will be granted access to Anasazi without successfully completing the Anasazi Training.

All forms with instructions are available electronically on the ASO's (OptumHealth) Public Sector website at https://www.optumhealthsandiego.com

Staff Assignment to Unit(s) and SubUnit(s)

On the ARF, the program manager will be assigning each staff to specific Unit(s) and SubUnit(s) based upon the program(s) where the staff performs work. Staff may be assigned to a single or multiple Unit/Subunits. The Unit/SubUnit number(s) must be reflected on the Anasazi Request Form. The MH MIS Unit will monitor staff access to Units/Subunits to ensure that staff has been assigned correctly. Under no circumstances, should a staff person be assigned to a Unit/Subunit if that staff person does not perform work for that program. This would constitute a violation of security and client confidentiality.

User Assignment to a Menu Group

Each user is granted restricted access to MH MIS based on his/her job requirements. One of the ways that access is restricted is through assignment to Units and Subunits described above. In addition, access is further restricted by assignment to a menu group. A menu group defines the screens and reports the user will be able to access and whether the user can add/edit or delete for each of those screens. For example, the user may only be able to view but not change data in one screen but may have rights to add data or edit previously entered data for another screen. Menu groups are created based on multiple criteria such as security, level of access to client information, staff job functions, staff credentials and state and federal privacy regulations.

On the ARF, the program manager or supervisor is responsible for requesting the menu group assignment for each user based on his/her job functions. A user may only be in one menu group at a time. Therefore, it is important for the program manager/supervisor to determine which menu group is the best match for the job functions performed by his/her staff.

For example, there will be menu groups for:

- Data entry staff with full client look up rights
- Data entry staff with limited client look up
- Clinicians
- Program managers and supervisors
- Quality Assurance
- Billing staff
- Research and Analysts

Refer to the ARF Instructions for a list and definition of available menus. The MH MIS Unit will review menu group requested by the program manager/supervisor and approve or modify the request.

Limitation of Staff Assignment to "Data Entry – Add New Clients" Menu Group

MANAGEMENT INFORMATION SYSTEM

Program staff will be allowed to view information about a client currently or previously served by their program. Designated program staff will be given access to the "full client look up" in order to add new clients and assign existing clients to their subunit (program). These individuals will be allowed to view all clients in the system, including those not served by their program. Due to security and privacy issues, each program will be limited to two staff that will have this higher level of access. This access allows for data entry, adding new clients, full client lookup; entering demographic, diagnosis, insurance, and financial information (UMDAP); opening assignments; and running reports. Requests for exceptions to the two staff rule must be made in writing directly to and approved by the MH MIS Unit.

Staff Access to Live Production and Training Environment in Anasazi

For most users, after logging on to Anasazi through the Citrix Access Gateway, two visible Anasazi icons will be available for selection. One icon provides access to the Live Production environment used for data entry and reporting. The other icon provides access to the Training environment which is a copy of the set up of the live environment populated with fictitious client data. The training environment is used to train all new and returning users. Access to the training environment will remain available for ongoing training purposes. For example, on occasion, when there are upgrades to the Anasazi application, it may be necessary for staff to first practice in the Training environment prior to utilizing new functionality in the Live Production environment. Program managers and staff will be notified of changes to application functionality and will be instructed as to when the training environment should be utilized.

Program Manager/Supervisor Responsibility for Staff Access and Security

NOTE !
For system security, providers must notify Optum Health when staff with access to Anasazi move, change jobs, or are terminated.

The program manager/supervisor shall ensure that staff is in compliance with all County, State and Federal privacy and confidentiality regulations regarding protected health information (PHI). In addition, the program manager shall ensure that his/her staff is aware of the County's Security Policy regarding the protection of network/application passwords and use of County systems and data as outlined in San Diego County's "Summary of Policy". The program manager shall immediately notify the MH MIS Unit whenever there is a change in staff information such as staff demographics, email, job title, credential/licensure, and Unit/Subunit assignment. This includes the initial staff setup, modifying or terminating existing staff accounts**. Under no circumstances shall a staff person who has terminated employment have access to the EHR through Anasazi. This would constitute a serious violation of security which may lead to disciplinary actions.**

Staff Termination Process

- **Routine User Termination –** In most cases, staff employment is terminated in a routine manner in which the employee gives an advanced notice. Within one business day of employee termination notice, the program manager shall fax to the MH MIS Unit (858) 467-

0411 a completed ARF with the termination date *(will be a future date).* The MH MIS Unit will enter the staff expiration date in Anasazi which will inactivate the staff account at the time of termination and process the CSRF to delete the County network Citrix account.

- **Quick User Termination –** In some situations, a staff person's employment may be terminated immediately. In this case, the program manager must immediately call the MH MIS Unit at (619) 584-5090 to request the staff account be inactivated immediately. Within one business day, the program manager shall fax a completed ARF to the MH MIS Unit (858) 467-0411.

The MH MIS Unit is responsible for inactivating both the Anasazi and Citrix staff accounts.

Application Training

Prior to staff obtaining access to Anasazi, he/she shall successfully complete the Anasazi training. Program managers are responsible for registering new and returning Anasazi users for training on the Anasazi application. The Quality Improvement (QI) Unit provides training on a regularly scheduled basis. Previous Anasazi users returning to employment after more than 90 days of absence will be required to attend refresher training.

User Manuals

Users should be familiar with the MH MIS User Manual and the Financial Eligibility and Billing Procedures Manual, which contain detailed information about program workflow requirements using the MH MIS. These manuals are available on line at https://www.optumhealth.com.

Security and Confidentiality

The County of San Diego is responsible for the protection of County technology and data and to monitor through its own policies and procedures user compliance with state and federal privacy and confidentiality regulations.

The County's Security mandates state that access will be given to a user at the least minimum level required by the user to execute the duties or job functions and that only those individuals with a "need to know" will be given access. Protection of County data and systems is also achieved via the use of unique user identification and passwords as well as other tracking methods.

Passwords

The sharing of passwords or allowing unauthorized individuals access into the system is strictly

prohibited. A user's password is his/her electronic signature that is not to be shared or made available to anyone. Programs must ensure that the County's Policy and Procedures regarding security and confidentiality as stated in the Summary of Policies is complied with at all times. Failure to comply with these polices and procedures can result in the temporary or permanent denial of access privileges and/or disciplinary action.
MH MIS passwords:

- Must be changed every 90 days
- Must have a minimum of 7 characters
- Must contain a mix of letters & numbers
- May NOT be reused
- Are case sensitive
- Will be rejected if common words or acronyms are used

Unauthorized Viewing of County Data

All terminals and computer screens must be protected from the view of unauthorized persons. All confidential client information, electronic or printed, shall be protected at all times.

User Support

Users can obtain support through the Optum Support Desk. The Optum Support Desk can assist a user with the MH MIS application (technical assistance), MH MIS password issues, connectivity/access problems, printer problems, data entry questions, special requests, such as reports and Citrix access issues for contractors. For Citrix access issues (i.e. password reset), County employees must contact the County IT vendor.

In some cases, the Optum Support Desk may refer the caller for second level user support, i.e. to the Mental Health Quality Improvement Unit for clinical issues and to the Mental Health Billing Unit for financial eligibility and billing issues.

The Optum Support Desk may be contacted as follows:

Phone: 1-800-834-3792
Fax: (619) 641-6975
Emails: sdhelpdesk@optum.com

- Optum Support Desk hours: Monday through Friday, from 6:00 am to 6:00 pm except on holidays.

The Optum Support Desk will provide after-hour cell phone emergency support for urgent Citrix and Anasazi issues. Urgent issues affecting multiple users include:

- When logging into Anasazi, the system does not respond or appears to be frozen, and/or no data can be entered or viewed
- For after-hour support use cell (800) 834-3792 on weekdays 4:30 am – 6:00 am and 6:00 pm – 11:00 pm and on weekends 4:30 am – 11:00 pm

For an operating system failure, contact your company's IT department. The IT department will determine the need for Optum Support Desk involvement.

NOTE: Printing issues, password resets, technical and Anasazi application questions are not considered an emergency and will be handled the next business day.

QUICK RESOURCE GUIDE

1. MH MIS Unit Phone: 6195845090
2. MH MIS Unit Email: MH_MIS_SystemAdmin.hhsa@sdcounty.ca.gov
3. MH MIS FAX (ARFs and SOPs): 8584670411
4. Optum Support Desk Phone: 18008343792
5. Optum Support Desk 24 Hour Pager: 6198934839
6. Optum Support Desk email: sdhelpdesk@optum.com
7. Web address to access Anasazi: https://mhmis.co.sandiego.ca.us
8. OptumHealth Public Sector Website: https://www.optumhealthsandiego.com
9. County MH MIS Website: www.misupdate.org

J. PROVIDER CONTRACTING

Note: References to contracting do not apply to County-operated programs.

All Medi-Cal providers shall adhere to the Managed Care Contract executed between San Diego County and the California State Department of Mental Health. As outlined in that contract, Medi-Cal contractors are prohibited from subcontracting with a "legal entity" as defined in the California State Medicaid Plan for Short-Doyle/Medi-Cal services. The California State Medicaid plan defines legal entity as each county mental health department or agency and each of the corporations, partnerships, agencies, or individual practitioners providing public mental health services under contract with the county mental health department or agency. The prohibition on subcontracting does not apply to providers and their relationships with vendors such as nursing registries, equipment, part-time labor, physicians, etc. Such providers do not meet the legal entity definition cited above. The legal entity concept prohibits a county from contracting with a legal entity to provide Short-Doyle/ Medi-Cal services that in turn contracts with another legal entity to provide Short-Doyle/Medi-Cal services.

All non-County-operated organizational providers must contract with the County of San Diego in order to receive reimbursement for Specialty Mental Health Services. Please read your contract carefully. It contains:

- General terms applicable to all contracts;
- Special terms specific to a particular contract;
- A description of work or services to be performed;
- Budget schedules; and
- Statutes and/or regulations particular to the Medi-Cal managed mental health care programs as well as programs supported by other funds.

All contracted providers will be expected to adhere to these requirements.

Program Monitoring

Each provider will have assigned to their program a Program Monitor (also known as Contracting Officer Technical Representative – COTR), who will monitor compliance with outcome measures, productivity requirements and other performance indicators, analyze reports from providers, and provide programmatic review for budgets and budget variances in accordance with contract terms and conditions. Program monitors/COTR's hold regular providers meeting to keep providers informed on the System of Care. All provider contract questions should be directed to the assigned Program Monitor/COTR.

NOTE!

Please read your contract carefully and keep it in a place where you can refer to it easily.

If you have any questions regarding your contract, please contact the Mental Health Services Contract Administration Unit at 619-563-2733.

PROVIDER CONTRACTING

Contractor Orientation
All new contracts require a contractor orientation meeting within 45 days of contract execution. Agency Contract Support shall be responsible for contractor orientation. Contractor will designate a contact person to coordinate attendance of necessary contractor staff at the orientation.

Notification in Writing of Status Changes
Providers are required to notify the Mental Health Services COTR and QI in writing if any of the following changes occur:

- Change in office address, phone number or fax;
- Addition or deletion of a program site;
- Change of tax ID number or check payable name;
- Additions or deletions from your roster of Medi-Cal billing personnel; or
- Proposed change in Program Manager or Head of Service.

Site Visits
The County MHP will conduct, at a minimum, an annual site visit to all organizational providers. The County MHP includes MHS Program Monitor/COTR/Designee, MHS Quality Improvement (QI) Unit, and the Health and Human Services Agency (HHSA) Contract Support. The site visit may include, but is not limited to, a review of:

- Compliance with contractual statement of work;
- Client medical records (where applicable);
- Building and safety issues;
- Staff turnover rates;
- Insurance, licensure and certification documentation;
- Fiscal and accounting policies and procedures;
- Compliance with standard terms and conditions.

Information from the site visit will be included in the contract monitoring process. For Medi-Cal providers, the site review is due at least annually. When a re-certification is due, the annual site review will be completed with the re-certification. Please see the *Quality Improvement Program* section of this handbook for a more detailed discussion of Medi-Cal provider site visits.

An additional note: Contractor's Program Manager shall be available during regular business hours and respond to the Program Monitor/COTR or Designee within 2 work days. Contractor shall have the technological capability to communicate, interface and comply with all County requirements electronically using compatible systems, hardware and software.

Corrective Action Notice
Corrective Action Notice (CAN) is a tool identifying deficiencies in compliance with contractual obligations and requires corrective actions within a specified time frame. A CAN may result from site visits or information derived from reports. Contractors are required to respond to the CAN specifying course of actions initiated/implemented to comply within the specified time frame.

Monthly Status Reports
Contracted providers are required to submit a completed Monthly Status Report (MSR) within 15 calendar days after the end of the report month. County Mental Health Administration has agreed to accept the MSRs on the 20th of each month until further notice. The MSR includes the NOA Log and Suggestion / Provider Transfer Request Log. Twice yearly, in July and December, the County submits a Cultural Competency Report to the State by extracting information provided on the MSR from the Staffing and Personnel as well as Training section of the MSR.

Contract Issue Resolution
Issues, problems or questions about your contract should be addressed to your Contracting Officer's Technical Representative (COTR) at their respective addresses.

Disaster Response
- In the event that a local, state, or federal emergency is proclaimed within San Diego County, contractors shall cooperate with the County in the implementation of a Behavioral Health Services response plan. Response may include staff being deployed to provide services in the community, out of county under mutual aid Contracts, in shelters, and/or other designated areas.
- Contractor shall provide BHS with a roster of key administrative personnel's after-hours phone numbers, pagers, and/or cell phone numbers to be used in the event of a regional emergency or local disaster. These numbers will be held confidential and never given out to other than authorized personnel.
- Contractor shall identify 25% of direct service staff to prepare for and deploy (if needed and available) to a critical incident. These staff shall participate in County provided Disaster Training (or other approved training) and provide personal contact information to be included in the Disaster Personnel Roster maintained by the County. Contractor shall advise COTR of subsequent year training needs to maintain 25% trained direct service staff in the event of staff turnover. Contractor shall maintain 25% staff deployment capability at all times.
- In the event that contractor's program site is closed due to disaster or emergency, contractor shall call the Access and Crisis Line and their COTR to inform them of this.

Transportation of Clients
Contractors shall not use taxi cabs to transport unescorted minors who receive services funded by the County of San Diego.

CLAIMS AND BILLING FOR CONTRACT PROVIDERS

Contractor Payments
Contractors will be paid in arrears. After the month for which service has been given, the Behavioral Health Services (BHS) Contract Fiscal Reimbursement Unit will process claims (invoices/cost reports) in accordance with the contract terms.

Budgets, Cost Reports and Supplemental Data Sheets and Claims (Invoices)
- Budgets, cost reports, supplemental data sheets, and claims (invoices) must comply with the established procedures in the State of California, Department of Mental Health, Cost Reporting/Data Collection Manual, dated July 1989.
- Quarterly Cost Reports are due by October 31, January 31, April 30.
- Year-end Cost report is due by August 31.

Submitting Claims (Invoice) for Services
Please submit all claims (invoice) for payment to:

Mental Health Services
BHS Contract Fiscal Reimbursement Unit (P531K)
P O Box 85524
San Diego, CA 92186-5524
Fax: (619) 563-2730, Attn: Lead Fiscal Analyst

Overpayment
In the event of overpayments, excess funds must be returned or offset against future claim payments.

Certification on Disbarment or Exclusion
Beginning April 1, 2003, all claims for reimbursement submitted must contain a certification about staff freedom from federal disbarment or exclusion from services. The details of this new procedure are laid out in the February 21, 2003, Letter from Health and Human Services Agency (HHSA) Contract Support and Compliance directed to all HHSA contractors.

In order to be in compliance with these federal regulations, all organizational providers must verify monthly the status of employee professional licenses with both the Office of the Inspector General (OIG) and Government Services Agency (GSA).

To verify through the Internet if someone is on the OIG Exclusion list or the GSA debarment list, go to:
http://oig.hhs.gov/fraud/exclusions/listofexcluded.html

To view the list of what will get someone placed on the OIG list, go to:
http://oig.hhs.gov/fraud/exclusions/exclusionauthorities.html

Please remember the following:

- Providers must retain the records verifying that these required monthly checks have been performed and the names of the employees checked.
- Any employees who appear on either the OIG or GSA lists are prohibited from working in any County funded program
- Providers are encouraged to consult with their compliance office or legal counsel should any of their employees appear on either of the exclusion lists.

License Verifications
As of July 1, 2003 all HHSA contractors are required to verify the license status of all employees who are required by the contract Statement of Work to have and maintain professional licenses. The verification must be submitted at the time of contract execution, renewal or extension. This is in accordance with the Proforma requirements. In order to ensure the license is valid and current, the appropriate website must be checked and documented.

SHORT-DOYLE MEDI-CAL

Per Cost Reporting/Data Collection Manual the "policy of the State Agency is that reimbursement for Short-Doyle Medi-Cal services shall be limited to the lowest of published charges, Statewide Maximum Allowances (SMA), negotiated rates or actual costs if the provider does not contract on a negotiated rate basis."

I. Definitions

Provider means the program providing the mental health services. It is part of a legal entity on file with the State Department of Mental Health.

Published Charge or Published Rate is a "term used in CFR Title 42 to define provider cost reimbursement mechanisms from third party sources. This generally means that customary charges throughout the year should be as close to actual (cost) as possible to avoid a lesser of costs or charges audit exception circumstance."
Published rates for services provided by organizational providers must be updated at the beginning of each fiscal year to ensure no potential loss of Medi-Cal revenue.

The published rate for a specific service should, at a minimum, reflect the total cost for providing that service to ensure no loss of Medi-Cal revenue.
Published rates are to be submitted to BHA Contract Fiscal Reimbursement Unit within 30 days upon receipt of request.

Statewide Maximum Allowances (SMA) are upper limit rates established for each type of service, for a unit of service. SMA is an annual rate for reimbursement of a SD/MC unit of service.

Negotiated Rate is a fixed prospective rate subject to the limitations of rate setting requirements.

Actual Cost is reasonable and allowable cost based on year-end cost reports and Medicare principles of reimbursement per 42 CFR Part 413 and HCFA Publication 15-1.

Federal Financial Participation per Title 9 CCR Chapter 11 means the federal matching funds available for services provided to Medi-Cal beneficiaries under the Medi-Cal program.

II. Medi-Cal Revenue

MIS will bill Medi-Cal for covered services provided to Medi-Cal beneficiaries by Short-Doyle Medi-Cal certified programs. For services that do not clear the billing edits, the State will issue Medi-Cal Error Correction Reports (ECRs) to the MHP's agent MH Billing Unit Fiscal Services, who will mail the ECRs to the appropriate providers. Providers need to make the necessary corrections to the ECRs and resubmit them within ten (10) business days at the following address:

County of San Diego HHSA – Mills Bldg.
Mental Health Billing Unit Fiscal Services
1255 Imperial Ave.
San Diego, CA 92101
Attn: Fiscal Services 6th Floor Rm 633

III. ***Medi-Cal Disallowance/Recoupment of Federal Financial Participation (FFP) Dollars***

Per the current California State DMH Reasons for Recoupment of FFP dollars, CMHS is obligated to disallow the Medi-Cal claim under the following categories:

- Medical Necessity
- Client Plan
- Progress Notes.

Located in *Appendix G. G.1*, is the complete listing of recoupment criteria based on the above categories. Organizational providers shall be responsible for ensuring that all medical records comply with federal, State and County documentation standards when billing for reimbursement of services.

The federal share of the Medi-Cal claims for the above circumstances will be deducted from your contract payment.

In accordance with State guidelines, these disallowances may be subject to future change.

Contractor shall reimburse CMHS for any disallowance of Short-Doyle/Medi-Cal payments, and reimbursement shall be based on the disallowed units of service at the Contractor's approved budgeted unit cost. The Federal share of the Medi-Cal claims for the above circumstances will be deducted from your contract payment.

In FY 04-05, the State announced that the State (non-Federal) share of EPSDT claims will also be subject to recoupment if any current or new recoupment criteria issued by the Department of Mental Health are met.

IV. *Billing Disallowances – Provider Self Report*

The policy of San Diego County Behavioral Health Services Administration (SDCBHS) is to recoup Federal Financial Participation (FFP) and Early Periodic Screening and Diagnostic Treatment (EPSDT) dollars by disallowing billing which has been identified and reported to the SDCBHS by the Contracted Organizational Providers and County Owned and Operated Clinics in accordance with documentation standards as set forth in the current California State Department of Mental Health "Reasons for Recoupment of Federal Financial Participation Dollars."

PROCEDURES

The following are the procedures to be followed for Self Reporting of Billing Disallowances to ensure consistent procedures are used when the information is reported to Behavioral Health Services Administration by providers.

Provider Requirements

1. Providers are required to conduct internal review of medical records on a regular basis (i.e. monthly) in order to ensure that the documentation meets all County, State and federal standards and that billing is substantiated.

2. If the review of a Medi-Cal client's chart results in a finding that the clinical documentation does not meet the documentation standards as set forth in the current California State Department of Mental Health "Reasons for Recoupment of Federal Financial Participation Dollars" the provider shall be responsible for addressing the issue by filing a self-report of billing disallowances with SDCMH.
3. To file a self-report of billing disallowances with SDCMH providers shall fill out one of the Provider Self-Report Billing Disallowance and Deletion forms and e-mail the form to MH Admin as directed on the form. If the service is prior to 10/1/08, they must use the InSyst form (*Appendix J. J.1)*. If the service is 10/1/08 or later, they must use the Anasazi form *Appendix J.J.2 – Tab 1*).
4. Providers shall ensure that the services listed on the form as disallowances are noted correctly and do not contain errors. Items that are listed on the form incorrectly are the responsibility of the provider to correct. All disallowed services must be listed on the form exactly as they were billed.
5. All services that are disallowed will also be voided from Anasazi. Providers are responsible for re-entering corrected service information for all billable and non-billable services as applicable based on the disallowance instructions (*Appendix A.J.1 or 2 – Tab 2*). Services that may be corrected will be identified in the Anasazi system with a code 33. Services with a QI disallowance and disallowance for reason of 1 to 7 & 14 per disallowance instructions cannot be re-entered; these services will be identified with a code 32.
6. Providers will receive confirmation from BHS Financial Management Unit when the services have been voided and disallowed. Once confirmation is received, if applicable, see disallowance instructions and re-enter the services.
7. In order to remove billing from EPSDT review, providers must send the Provider Self-Report Disallowance and Deletion form prior to receipt of notification that an EPSDT review has been scheduled for that provider. Items received less than 21 calendar days prior to the receipt of notification that an EPSDT review has been scheduled may not be fully processed and therefore may not be removed from the EPSDT review, and may still be subject to recoupment by DMH. (Please note: There is a possible DMH update on this matter- this standard may be changed by DMH in the near future. Providers are accountable for knowing about any changes in regulations made by DMH through DMH Letters and Notices. If a change is made by DMH providers should not wait for County notice or updates to the handbook to recognize the change).

Contract Administration Unit Procedures

1. On an annual basis, the Contract Fiscal Reimbursement Unit will prepare a letter pertaining to disallowances that will be sent to Contractors indicating that the County shall be entitled to recoup the disallowances.

2. During year end reconciliation, Contract Fiscal Reimbursement staff will ensure that all disallowances are included in the calculation of the year-end provider payment settlement. Notices will be sent to all Contractors that are entitled to additional payment or are subject to recoupment because of overpayment to the Contractor.
3. Contractors that have been overpaid may elect to repay the recoupment via check or an offset from future payments.
   - If the contractor pays by check, the check is received by Contract Fiscal Reimbursement staff and forwarded to Financial Management staff for deposit. The payment is logged in the contract file along with a copy of the payment.
   - If no check is received by the Contract Fiscal Reimbursement staff within 15 business days from the date of the letter to the Contractor; the recoupment amount is deducted from the next scheduled provider payment.

Billing Inquiries

Questions regarding claims (invoice) for payment should be directed in writing to:

Mental Health Services
BHS Contract Fiscal Reimbursement Unit (P531K)
P O Box 85524
San Diego, CA 92186-5524
Attn: Lead Fiscal Analyst

Questions can also be addressed by calling the Lead Fiscal Analyst 619-563-2729.

County Operated Mental Health Services

County programs are required to follow County Policy.

Contractors Inventory Guides For A Cost Reimbursement Contract

1. **Inventory Acquisition**:
When a contract budget with capital assets and minor equipment funding is approved, a Contractor may acquire property with funds from this contract. If contract payments are on a cost reimbursement basis, including property acquired by lease purchase agreement, the County retains ownership to all property.

2. Definitions:

2.1. **Capital Assets** (previously referred to as fixed assets): Includes property such as furniture, machines, tools and vehicles. Items costing $5,000 or more shall be budgeted in the appropriate capital asset account.

2.2. **Minor Equipment**: Individual items that cost less than $5,000 and are useful for one (1) year or longer are categorized as Minor Equipment.

- **Non-consumable** supplies (of a relatively permanent nature with useful live of one year or longer) costing less than $5,000 should be listed on the inventory list as minor equipment.

- **Consumable** supplies valued under $500 are not considered minor equipment.

NOTE: Beginning with FY July 2010- June 2011 do not list consumable supplies valued under $500. For previous fiscal years, do not remove the items previous listed (valued from $100 to $499) unless they were returned to the County.

3. BHS Property Inventory Form - The Process for Cost Reimbursement Contracts and Record Keeping:

3.1. All purchases or leases reimbursed by a County funded contract shall be listed on the Behavioral Health Services (BHS) Inventory Form (Appendix J, J.3), or the contractor's form with the required information, with the exception of property having the value of zero. Capital assets and minor equipment should be accounted for at cost or, if the cost is unknown, estimated cost at time of acquisition. Inventory records on property shall be retained, and shall be made available to the County upon request, for at least three (3) years following date of disposal.

3.2. Contractors will maintain equipment records that include a description of the property, a serial number or other identification number; the acquisition date; the acquisition costs; location of the property; condition of the property; program funding for the property; and any ultimate disposition data including the date of disposal.

3.3. Contractor may not expend funds under this agreement for the acquisition of property having a unit cost of $5,000 or more and a normal life expectancy of more than one (1) year without the prior written approval of the Contracting Officer's Technical Representative (COTR). After approval from the COTR, as contractors acquire capital assets, notify the COTR by including the expenditure on the monthly invoice/cost report.

3.4. As the contractor acquires equipment, they will notify the COTR within 30 days by including the expenditure on their monthly invoice/cost report. The COTR will forward the tags that identify the object as "County of San Diego PROPERTY". The contractor is responsible for immediately attaching the labels to the property.

4. Inventory Disposition

4.1. Contact the COTR before disposing of property purchased with County funds.
Non-expendable property that has value at the end of a contract (e.g. has not been fully depreciated with a value of zero), and which the County may retain title under this paragraph, shall be disposed of at the end of the Contract Agreement as follows:

4.2. At County's option, it may:

4.2.1. Have contractor deliver to another County contractor or have another County contractor pick up the non-expendable property;

4.2.2. Allow the contractor to retain the non-expendable property provided that the contractor submits to the County a written statement in the format directed by the County of how the non-expendable property will be used for the public good;

4.2.3. Direct the Contractor to return to the County the non-expendable property.

5. BHS Property Inventory Form:

5.1. As the contractor disposes of equipment the following columns on the BHS Inventory form must be completed and a copy provided to the COTR:

5.1.1. "Date of Disposition of Capital/Fixed Assets or Minor Equipment": This is the actual date the item was delivered and accepted by County Salvage.

5.1.2. "Date form AUD253 completed": This is the date the COTR signs and returns AUD253 form to the contractor.

6. **AUD253 Property Loan or Transfer Request Form:**

NOTE: Procedure for Property transfer to the County of San Diego – Property Disposal or transfer to another contractor. Form AUD253 will be provided to the Contractor by BHS and shall be signed by the Contractor's program manager. BHS Contract Administrators will keep an internal record of any County-owned property and conduct an inventory of all County-owned property during selected site visits.

The Contractor shall repair or replace, at the Contractor's expense, any County owned property damaged or lost as a result of Contractor negligence. Further, the Contractor shall exonerate, indemnify and hold harmless the County from and against any and all claims for

any damage resulting from the use, misuse, or failure of County-owned property/equipment, whether such damage be to an employee or property of the Contractor, other contractors or other persons or property.

7. Electronic Property/IT:

Contractors Inventory Minimum Guidelines On A Cost Reimbursement and Fixed PRICE Contract

Inventory responsibility includes these minimum guidelines for the security of client information and portable electronic and data storage devices. This responsibility exists whether the information is in paper or electronic form. Additionally, all Contractor employees have the duty to protect any County assets assigned to them or in their possession, including desktop computers, portable devices and portable media.

Definitions:
Client Data: Any identifying information relating to any individual receiving services from any program.

Portable Devices: Tools such as laptops, external hard drive, PDAs, Blackberries, Tablet PCs, other USB memory devices and cameras (digital, non-digital, and video).

Portable Media: Any tool used to transport information any distance such as floppy disks, CDs, DVDs, USB memory sticks, flash drives or smart cards.

Minimum Guidelines:
All Contractors' executives shall be responsible for maintaining a current inventory of all portable devices and portable media in their program.

1. All Contractors' electronic devices shall be password protected.
2. All client data transported on any portable device or media shall be encrypted and/or password protected.
3. Portable devices or portable media shall not be used for routine storage of client data.
4. For major confidentiality breach (lost or stolen laptop, client files/records accessed, etc.) refer to *Serious Incident Reporting to Quality Improvement Unit* procedures.

K. PROVIDER ISSUE RESOLUTION

The MHP recognizes that at times providers may disagree with the MHP over an administrative or fiscal issue and will be happy to work with them to solve the problem. There is both an informal and formal Provider Problem Resolution Process for providers who have concerns or complaints about the MHP.

Informal Process

Providers are encouraged to communicate any concerns or complaints to the Program Monitor/COTR or designee. The Program Monitor/COTR or designee shall respond in an objective and timely manner, attempting through direct contact with the provider to resolve the issue. When issues are not resolved to the provider's satisfaction informally, a formal process is available. A copy of complaint materials will be sent to the County Mental Health QI Unit.

If the provider is not satisfied with the result or the informal process or any time, the formal process below is available:

Formal Provider Problem Resolution Process

1. Providers shall submit in writing any unresolved concerns or complaints to the Chief, Behavioral Health Services Contracts Support or designee, using the **Formal Complaint by Provider** form (located in *Appendix K. K.1.*)
2. Written narration shall include all relevant data, as well as, attachment of any documents, which support the provider's issue(s).
3. Formal complaint shall be submitted within 90 calendar days of original attempt to resolve issue(s) informally.
4. The Chief, BHS Contracts Support or designee shall have 60 calendar days from the receipt of the written complaint to inform the provider in writing of the decision, using the **Formal Response to Complaint** form (see *Appendix K. K.2.*)
5. The written response from the Chief, BHS Contracts Support or designee shall include a statement of the reason(s) for the decision that addresses each issue raised by the provider, and any action required by the provider to implement the decision.
6. Formal Provider Problem Resolution documentation is to be directed to:

Chief, BHS Contracts Support
P O Box 85524
San Diego, CA 92186-5524
Mail Stop: P531-K

7. A copy of all complaint materials shall be sent to the County Mental Health QI Unit.

Formal Provider Appeal Process

1. Provider may submit an appeal within 30 calendar days of written decision to the Formal Complaint.
2. Formal Provider Appeals concerning Children's Services shall be submitted in writing to the Assistant Deputy Director (ADD) for Children's Services. The appeal shall be submitted using the **Formal Appeal by Provider** Form (*see Appendix K.K3).*
3. The Appeal Form shall summarize the issue(s) and outline support for appeal. Previous documents on the issue(s) shall be attached.
4. The ADD shall notify the provider, in writing, of the decision within 60 calendar days from the receipt of the appeal and supporting documents, using the **Formal Appeal Response form** (see *Appendix K. K.4.*)
5. The written response from the ADD shall include a statement of the reasons for the decision that addresses each issue raised by the provider, and any action required by the provider to implement the decision.
6. Formal Provider Appeal documentation is to be directed to:

   Assistant Deputy Director of
   Children's Mental Health Services
   P.O. Box 85524
   San Diego, CA 92186-5524
   Mail Stop: P531-C

7. A copy of all appeals materials should be sent to the County Mental Health QI Unit:

   Quality Improvement Unit
   P.O. Box 85524
   San Diego, CA 92186-5524
   Fax: (619) 584-5018
   Mail Stop: P531-Q (Children)

Quality Improvement Process

1. The Quality Improvement Unit shall gather, track and analyze all formal provider problem resolution issues.
2. All Organizational Providers who submit a formal complaint and/or formal appeal shall send a copy to the Quality Improvement Unit.

3. All Program Monitors or designees, the Chief, BHS Contracts Support who obtain s a formal complaint, and/or the ADD who handles an appeal shall forward a copy to the Quality improvement Unit, attaching the response.
4. The Quality improvement Unit will log all formal complaints and appeals as it pertains to issue, timeline compliance, resolution disposition and action plan. This unit will identify opportunities for improvement and decide which opportunities to pursue, design and implement interventions to improve performance, and measure the effectiveness of any interventions.

Complaints and Appeals for Denial of Authorization or Payment for Services (for Day Treatment Programs)

Providers have the right to access the provider appeal process at any time before, during or after the provider problem resolution process has begun when the complaint concerns a denied or modified request for MHP authorization or a problem with processing of a payment, or a billing disallowance.

Providers appealing a denial of authorization or payment must submit a written complaint within 90 days of the receipt of the denial to their County Regional Coordinator/Program Monitor/COTR. The written complaint should include the client name, Case Number, date of authorization/payment denial and/or dates of all service(s), along with any specific information relevant to the complaint. (See Authorization of Reimbursement for Services section of this Handbook for more information on denials.)

All such complaints will be logged and a response will be issued within 30 days about action or denial. At any time within 90 days of the original attempt to resolve the issue informally, providers may appeal any decision made by the Regional Coordinator by submitting an appeal to the County Mental Health Director or his designee. The appeal should include the client name, Case Number, date of authorization/payment denial and/or dates of all service(s), along with a copy of the Program Monitor/COTR's letter of response. The County Mental Health Director or his designee will have 30 days to make a final decision on the appeal and respond back in writing to the provider.

Contract Administration and Fiscal Issues with MHP Contracts

Please see the Provider Contracting section of this Handbook.

PROVIDER ISSUE RESOLUTION

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L. PRACTICE GUIDELINES

Practice guidelines refer to methods and standards for providing clinical services to clients. They are based on clinical consensus and research findings as to the most effective best practices and evidence-based practices available. Because they reflect current interpretations of best practices, the guidelines may change as new information and/or technology becomes available. Special efforts must be given in respect to the unique values, culture, spiritual beliefs, lifestyles and personal experience in the provision of mental health services to individual consumers. Providers shall comply with standards as may be adopted by the Mental Health Clinical Standards Committee. This Committee sets standards of care for Mental Health within the county, develops system-wide guidelines, and includes representatives from County and Contract programs.

Comprehensive, Continuous, Integrated System of Care (CCISC) Model

Clients with co-occurring mental health and substance use issues are common in the public mental health system and present with complex needs. Therefore, San Diego County has adopted the Comprehensive, Continuous, Integrated System of Care (CCISC) Model, which is an integrated treatment approach for individuals with co-occurring psychiatric and substance disorders. This model encourages programs to complete a Welcoming Statement as one of the first steps of becoming integrated. In addition, all clients must be routinely assessed for co-occurring disorders, and younger children may be impacted by substance use or abuse on the part of their caretakers. Be aware that some children in San Diego have been identified as beginning to use substances as early as age 6 and this must be assessed, particularly in high risk family situations. When serving a child, adolescent, or family that meets the criteria for co-occurring disorders these guidelines must be followed:

- Include substance use and abuse issues in your intake assessment and assessment updates, included on the Behavioral Health Assessment. In addition, use any screening tools that may be adopted or required such as the CRAFFT.
- If both types of disorders are present in the client at diagnostic levels, list the mental health diagnosis as the primary disorder and the substance use diagnosis as the secondary disorder. This indicates that the mental health diagnosis will be the primary focus of treatment, not necessarily that the mental health disorder is the more important disorder or the cause of the substance use.
- Treatment planning should deal with the substance use issue, either by referral or direct treatment. Even if the client or family is referred for substance abuse treatment, the client plan should document how that treatment will be coordinated or integrated into mental health treatment.
- Progress notes should be carefully stated to remain within Medi-Cal guidelines. If the substance use is in a collateral person, the progress note must focus on the impact of the substance use on the identified client. Though notes may focus solely on substance use in

an EPSDT client, this is permissible only if treatment for the substance use disorder is not otherwise available. In most instances, it is preferable to approach the substance use in the context of the mental health disorder, and create an integrated note and treatment regime.

- It is not appropriate to exclude a client from services solely because of the presence of a substance use disorder or a current state of intoxication. This decision should be made based on the client's accessibility for treatment, as well as client and provider safety concerns.

CMHS dual diagnosis capable programs must self monitor their capability by using the COMPASS survey (for programs on an annual basis) and the CODECAT (for clinicians).
Programs must have an identified lead and selected CADRE members available for trainings.
Indication of designated staff and completion of surveys will be made on MSR's.
After a program completes the COMPASS, they must develop an action plan which incorporates:

- ✓ Screening
- ✓ Assessment
- ✓ Treatment Plan
- ✓ Progress Notes
- ✓ Discharge summary
- ✓ Medication planning when appropriate
- ✓ Referrals

Programs in the system are dual diagnosis capable, in that they address co-occurring mental and substance-related disorders in their policies and procedures, assessment, treatment planning, program content and discharge planning. In addition, there are some dual diagnosis enhanced programs that have a higher level of integration of substance abuse and mental health treatment services and provide treatment to clients who are more symptomatic and/or functionally impaired as a result of their co-occurring mental disorder.

The MHP's Access and Crisis Line is also available for mental health and alcohol and drug services information and referral 24 hours a day, 7 days a week.

Drug Formulary for Mental Health Services

The Medi-Cal Formulary shall be adopted by all programs and physicians as the San Diego County Mental Health Services (MHS) formulary.

All clients, regardless of funding, must receive equivalent levels of care at all MHS programs. This includes the medications prescribed. The guidelines below will allow clinical discretion while including fiscal restraints in order to maximize available resources.

The criteria for choosing a specific medication to prescribe shall be:

1. The likelihood of efficacy, based on clinical experience and evidence-based practice
2. Client preference
3. The likelihood of adequate compliance with the medication regime
4. Minimal risks from medication side effects and drug interactions.

If two or more medications are equal in their satisfaction of the four criteria, choose the medication available to the client and/or the system at the lowest cost. Programs shall provide information to all appropriate staff as to the typical cost for all drugs listed on the Medi-Cal Formulary, at least annually.

For all initial prescriptions, consideration should be given to prescribing generic medication rather than brand name medication unless there is superior efficacy for the brand name medication of the side effect profile favors the brand name medication.

Providers shall follow the State guidelines for preparing a Treatment Authorization Request (TAR).

Assembly Bill 2726

AB 2726 is a program designed to provide mental health services to special education students who need the services to benefit from their education. All AB 2726 services are provided on a voluntary basis. Students are eligible for services from three years old up to age twenty-two or until graduation. The students must have a mental health issue that prevents them from benefiting from educational services, and who do not respond to counseling provided by the school. School districts are responsible for the identification and referral for assessment of students who may require services under AB 2726. CMHS/AB2726 staff is responsible for providing a mental health assessment and referral to appropriate mental health services based on the results of the assessment.

Assessments, referrals, placement, and case management services are provided at the request and acceptance of the parents and are free of charge. Upon completion of the assessment, the mental health services that are the least restrictive and appropriate are identified on the student's Individualized Education Program (IEP). Possible recommendations for mental health services include outpatient, day treatment, residential, or no services. The Mental Health Treatment Plan developed by the assessor identifies the areas of need and establishes treatment goals. Upon parental acceptance of AB2726 services, the Mental Health Treatment Plan becomes part of the student's IEP and is included in the referral to the appropriate provider. Case management services for outpatient and day treatment students are provided by contractors while case management for residential students remains the responsibility of the AB2726 staff. Case

management services are designed to promote access to educational, medical, social, pre-vocational, vocational, rehabilitative, or other needed community services for the eligible individuals by providing consultation, coordination, referral, and linkage.

All AB2726 mental health providers shall abide by the rules and regulations as set forth in the Local AB2726 Interagency Agreement and the California Education Code as related to Mental Health Services. If the County is required to pay for the cost of private treatment as a result of an AB2726 due process action where the Contractor has not complied with the AB2726 policies and procedures, Contractor shall reimburse the County for the cost of the private treatment paid by the County.

AB2726 Clients: Discharge

Discharge may occur when a student has met the mental health IEP goals, a change in the mental health level of care may be indicated, or the client is refusing mental health services. The mental health program will coordinate discharge planning with the school district liaison(s) before providing any specific information to the client. Programs shall not discharge a student without requesting an IEP review. Discharge recommendations regarding need for mental health services will be developed in accordance with AB2726 guidelines and may require a request for reassessment through the IEP process. Stay put orders apply in cases of Due Process.

Any and all changes to the student's IEP must be reviewed by the IEP team members, which include at a minimum: a program clinician, the district of residence, and the client/parent. Discharge summaries shall clearly address student progress on IEP goals and other treatment issues.

AB 2726 Clients: Medication Monitoring

Medication evaluation and/or medication management services are provided under the required provisions of the AB 2726 program and are at no cost to the client/parent (per Section 60020, Education Code. Authority: Section 7587, Government Code). The medication itself is not a benefit covered by the AB 2726 program nor does the County incur this service or cost.

The following are some general guidelines to assist clients and families in obtaining assistance with medication and laboratory costs:

AB2726 Clients: IF CLIENT HAS MEDI-CAL

Program Psychiatrist can write a prescription and have the client fill it at a Medi-Cal participating pharmacy, as is the current procedure.

AB2726 Clients: IF CLIENT HAS HEALTHY FAMILIES

Program staff, clinician, or Psychiatrist should work with the client's Primary Care Physician to see if they will provide medication if provided with a consultation or Psychiatric Evaluation by

the program Psychiatrist. Providers should be aware that Healthy Families may refer the student back to County Mental Health for an assessment. If this occurs and the client is diagnosed with a Severe Emotional Disturbance (SED), then the program would be responsible for medication under the Healthy Families carve-out.

AB2726 Clients: IF CLIENT/FAMILY HAS PRIVATE INSURANCE
Refer to services covered by family's private insurance plan.
(Parents/Clients with private insurance coverage will be helped by the passage of The Mental Health Parity Law (AB 88) in 1999. AB 88 requires most California health care plans to cover the diagnosis and medically necessary treatment of serious mental illness and emotional disturbances of a child on terms equal to their health plan medical coverage.)

AB2726 Clients: IF CLIENT'S/FAMILY'S PRIVATE INSURANCE HAS NO MENTAL HEALTH BENEFIT
Program should verify with insurance plan if mental health is a covered benefit due to the Mental Health Parity Law (AB88). Mental health program Psychiatrists may be able to provide sample medications or work with the client's Primary Care Physician to see if they will provide medication if provided with a consultation or Psychiatric Evaluation by the program Psychiatrist.

AB2726 Clients: IF CLIENT IS INDIGENT
Every effort must be made to link the family to other resources in the community.

Program Psychiatrists may be able to provide sample medications or work with the client's Primary Care Physician to see if they will provide medication if provided with a consultation or Psychiatric Evaluation by the program Psychiatrist.

Program can provide financial screening to determine the annual client liability for mental health services using the "Uniform Method for Determining Ability to Pay" (UMDAP) method. Following the financial screening, the Program Manager must approve all clients who will be receiving medication through the program.

AB2726 Clients: Outpatient Standards
Outpatient service requirements for standards of practice with regard to provider/school interactions on behalf of AB2726 students have been established and are to be documented in the medical record as follows:

- Timeline for Intake within 7-10 calendar days
- Upon receipt of assignment the clinician shall contact the school contact person
- A face-to-face contact between the therapist and school person (teacher or other

designated contact person) within the first 60 (sixty) days of treatment.

- A minimum of monthly contact with the school contact thereafter to include discussion regarding medication effectiveness as well as academic status and behavioral management.
- A home visit by the therapist during the course of treatment. Exception shall include justification in the medical record as to why a home visit is not clinically indicated. (Justification for exception of the home visit for existing clients who have been in treatment a year or more may be the length of time they have been in treatment already and the move to termination).
- Attendance of therapist, or knowledgeable representative from the mental health program, at IEP meetings when a major educational placement change may occur, at annual review and at the end of treatment.
- Quarterly Progress Mental Health IEP Reports shall be submitted to the client/parent and the teachers—(refer to Mental Health IEP Reporting section below)
- Comply with Time lines for Requests for Information and Records. Under the Individuals with Disabilities Education Act, pupil records are subject to the federal FERPA and state pupil records provisions, including state rules on providing copies to parents. All AB2726 parent/client requests for pupil records are to be completed and delivered to the parent/client within 5 (five) calendar days. Any request for release of pupil records must be accompanied by a signed authorization for release of those records.

AB2726 Clients: Mental Health IEP Reporting

- The outpatient clinician shall contact the student's teacher monthly to discuss progress and concerns. This contact shall be recorded in the client's medical record.
- The outpatient clinician shall submit the "Quarterly Progress Mental Health IEP Report" (*Appendix L. L.1*) to the parent/caregiver and school contacts on a quarterly basis. This report shall document the student's progress on the Mental Health IEP goals addressed through outpatient services. A copy of this report shall be maintained in the client's medical record.
- The outpatient clinician shall coordinate the AB 2726 outpatient mental health services with all other counseling services the student is receiving that are documented on the IEP. Evidence of such service coordination shall be documented in the client's medical record.
- The outpatient clinician shall update the "Mental Health Treatment Plan" (*Appendix L. L.2*) at the Benchmark/Short Term Objective time frames listed on the form. Clinician

shall complete an updated "Mental Health Treatment Plan" every six months, and request an IEP meeting for IEP team to review and accept updated plan. (Note: to reconvene an IEP meeting, the outpatient provider completes a "Need for IEP Review"- {*Appendix L. L.3*} and forwards it to the school contact). Please note that the Clinician needs to maintain all signed, updated IEP's in client's medical record.

AB2726 Clients: Medication Only Cases

If a client is assessed to solely need medication management services during their intake period, Program Monitor/COTR approval is required for initial Medication Only cases. Every medication only case must have, at a minimum, one behavioral health assessment.

When a therapist and psychiatrist in the same clinic are seeing a client, and a determination is made that the case shall be transitioned to a medication only case, the following shall occur:

1. Clinician completes a progress note to outline rationale for transitioning case to medication only.
2. The Assessment is updated to briefly outline move to medication only date / rationale. The assignment is kept open in Anasazi. However, the assignment has to be updated to change servers and reflect the name of the physician.
3. If during the medication only time frame the client experiences a crisis and is in need of therapeutic services, a clinician can provide Crisis Intervention without needing to change the assignment to a new server. Although there is no limit on the number of CI contacts, each of the CI contacts must clearly document acuity.

In incidents where it is determined that the client is again in need of ongoing therapeutic services (mental health services and/or case management), the following shall occur:

1. Program shall determine if current Utilization Review (UR) authorization is in place.
    a. Client may still be covered by initial 6-month time frame from opening of assignment.
    b. Last UR Authorization conducted may still be current.

2. When authorization is in place, therapy may resume, however a new Client Plan is indicated.
3. When authorization for outpatient services has expired, the UR Committee must first authorize services for therapy to resume (in a case of a crisis, refer to item 5 above).
4. Once case transitions back to mental health and/or case management services, the UR Cycle is once again tracked to insure all services provided are authorized.
5. The assignment opening date continues to guide the requirement for completing the Mental Health Assessment, and in some instances triggers the need for other expired paperwork (such as exchange of information) to be updated.
6. Clinicians will update the assignment to reflect the new server and to show that client is transitioning out of meds only status.

AB2726 Clients: Day Treatment Standards

The goal of the AB2726 Day Treatment program is to re-integrate the students into a less restrictive educational setting in an appropriate school district classroom or non-public school. Consideration shall be given to developmental age as well as chronological age of student. Any exception to the age range specified for the program requires the approval of the Chief, Mental Health Special Education Services or designee.

Services shall maximize involvement of the family by providing opportunity for families to be involved and support the students' mental health treatment and education. These opportunities shall be in addition to family participation in family therapy sessions. For family therapy sessions, evening appointment hours shall be available at least two different nights per week. Evening hours shall be prominently posted in reception area and printed on all documents containing hours of operation information. For specific process and outcome objectives for AB2726 Day Treatment programs, please see the Systems of Care section of this manual.

Core services for AB 2726 day treatment shall include:

- Weekly individual and family (biological and /or extended) therapy.
- Three times weekly group therapy, including specialty groups designed to address specific needs of students in the program (for example, to address depression, anger management, substance abuse, social skills). Title 9 and CMHS guidelines, when indicated, shall provide alcohol and drug assessment and treatment services including COD groups, and referrals, as specified.
- Psychiatric Services and Medication Support shall be included in program service functions.
- Other services to be provided may include but are not limited to, art and music therapy; home visits; and recreational therapy focused on the interpersonal and therapeutic goals of the student.
- Multiple family groups, parenting training, parent support groups and/or other alternate activities designed to involve the family, including siblings, in the treatment and educational program.
- Daily community meetings shall be held and may include the teacher(s) and aides as well as mental health staff.
- Case management services to student and family including, but not limited to:
    - Participation in Treatment Team meetings and IEP meetings.
    - Monthly contact with the parents/significant support person

- Monitoring and reporting to IEP team the student's progress towards achieving the mental health IEP treatment goals.
- Updating mental health IEP goals as appropriate.
- Acting as a liaison with the student's home school district.
- Linkages to other appropriate community resources.

Contractor shall adhere to youth transition planning in accordance with MHS guidelines. Contractor shall coordinate transitional services between its program and HHSA Adult / Older Adult Mental Health Services. (Adolescent Programs Only).

Regional Mental Health AB2726/Special Education Services program managers:

North Coastal/Poway
Program Manager
340 Rancheros Dr., Suite 298
San Marcos, CA 92069
(Tel.) 760-752-4900
(Fax) 760-752-4924

North Inland/East Region/South
Program Manager
3692 Midway Drive
San Diego, CA 92110
(Tel.) 619-758-6240
(Fax) 619-758-6250

Central Region
Program Manager
3320 Kemper St., Suite 104
San Diego, CA 92110
(Tel.) 619-758-6217
(Fax) 619-758-6209

Administration
3320 Kemper Street, Suite 206
San Diego, CA 92110
(Tel.) 619-758-6227
(Fax) 619-758-6255

PRACTICE GUIDELINES

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M. STAFF QUALIFICATIONS AND SUPERVISION

Each provider is responsible for ensuring that all staff meets the requirements of federal, State, and County regulations regarding licensure, training, clinician/client ratios and staff qualifications for providing direct client care and billing for treatment services. Documentation of staff qualifications shall be kept on file at the program site. Provider shall adhere to staff qualification standards and must obtain approval from their Program Monitor/COTR or designee for any exceptions.

Provider shall comply with the licensing requirements of the California Welfare and Institutions Code Section 5751.2. Provider shall have on file a copy of all staff licenses and ASW/IMF certificates of registration with the Board of Behavioral Sciences. For staff positions requiring licensure, all licenses and registrations must be kept current and be in active status in good standing with the Board of Behavioral Sciences.

Staff Qualifications

- Contractor's program staff shall meet the requirements of Title 9, Division 1, Article 8 and Title 9, Chapter 11 of the California Code of Regulations as to training, licensure, and clinician/client ratios. All staff shall operate within the guidelines of ethics, scope of practice, training and experience, job duties, and all applicable State, Federal, and County standards. Contractor shall provide sufficient staffing to provide necessary services and Medicare approved services to Medicare covered clients. Current and previous documentation of staff qualifications shall be kept on file at program site.
- Psychotherapy shall be performed by licensed, registered, waivered, or trainee (with co-signature by LPHA) staff in accordance with State law.
- Psychiatrists shall have completed a training program in a child or adolescent specialty (must be Board eligible in child and adolescent or adolescent psychiatry), for programs that serve youngsters under 13 years of age, or have 5 years of experience offering psychiatric services to children and adolescents. Any exception to this must be approved by the Mental Health Services Clinical Director and the COTR.
- Nurses and Psychiatric Technicians may bill Medication Support to Medi-Cal under the non-MD Anasazi service code 20, as long as the service provided is within the individual's scope of practice and experience and documentation supports the service claimed.
- Qualified Mental Health Professionals (QMHP) / Mental Health Rehabilitation Specialist who provide direct, billable service must hold a BA and 4 years experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational

adjustment. Up to two years of graduate professional education may be substituted for the experience requirements on a year for year basis. Up to two year of post associate arts clinical experience may be substituted for the required educational experience in addition to the requirement of four years of experience in a mental health setting. Staff work under the direction of a licensed or waivered staff member.

- Rehabilitation Staff (non-licensed, non-waiverable, also referred to as Para Professionals) who provide direct, billable service at a minimum must have a high school diploma/GED, be 18 years old, have at least one-year full time (or equivalent) experience working with children or youth, a positive reference by a supervisor from that work experience, and must work under the direction of a licensed or waivered staff member.
- Family / Youth Support Partners who provide direct, billable service must have direct experience as the parent, care giver, or consumer in a public agency serving children, and demonstrate education and/or life experience commensurate with job duties. Youth (at least 12 years of age and up to 25 years of age) must meet work permit requirements when applicable. Partners must receive on going training and work under the direction of a licensed or waivered staff member.
- All direct service staff shall have had one year of supervised experience with children and adolescents.
- Any exceptions to these requirements must be approved by the COTR.

Clearances for Work with Minors.

Contractor's employees, consultants, and volunteers, who work under given contract and work directly with minors, shall have clearances completed by the contractor prior to employment and annually there after.

- Employees, consultants, and volunteers shall successfully register with and receive an appropriate clearance by "Trustline" (http://www.trustline.org/) or equivalent organization or service that conducts criminal background checks for persons who work with minors. Equivalent organizations or services must be approved by the COTR prior to use by contractor.
- Employees, consultants, and volunteers shall provide personal and prior employment references. Contractor shall verify reference information, and employees, consultants, and volunteers shall not have any unresolved negative references for working with minors.
- Contractor shall immediately remove an employee, consultant, or volunteer with an unresolved negative clearance.

Professional Licensing Waiver Guidelines -Welfare and Institutions Code (W&IC) Section 5751.2.

STAFF QUALIFICATIONS AND SUPERVISION

The W&IC Section 5751.2 (a): States that except as provided in this section, persons employed or under contract to provide mental health services pursuant to this part shall be subject to all applicable requirements of law regarding professional licensure, and no person shall be employed in local mental health programs and provide services for which a license is required, unless the person possesses a valid license.

- This applies to all psychologists, clinical social workers or marriage and family therapists employed by, or under contract to local mental health programs.
- This applies to both county employees and contract providers.
- This applies regardless of payer source.
- This does not apply to persons employed by or under contract to health facilities licensed by the California Department of Public Health. Waiver requests for these persons should be directed to the California Department of Public Health.
- The phrase "Mental Health Services" in this section refers to those types of treatment and services that require the practitioner to hold a license.

The W&IC Section 5751.2 (b): States that persons employed as psychologists and clinical social workers, while continuing in their employment in the same class as of January 1, 1979, in the same program or facility, including those persons on authorized leave, but not including intermittent personnel, shall be exempt from the requirement of subdivision (a).

- In order to qualify under this section, an individual would need to be employed in the same position and facility in which she/he was employed on January 1, 1979. There are probably only a few, if any, persons Statewide still in this category.

The W&IC Section 5751.2 (c): States that while registered with the licensing board of jurisdiction for the purpose of acquiring the experience required for licensure, persons employed or under contract to provide mental health pursuant to this part as clinical social workers or marriage, family, and child counselors shall be exempt from subdivision (a). Registration shall be subject to regulations adopted by the appropriate licensing board.

- Licensed Clinical Social Worker (LCSW) and Licensed Marriage and Family Therapist (LMFT) candidates do not need a waiver, nor can one be obtained. (See the exception

to this statement under Section 5751.2 (e) below for license-ready persons recruited from outside California.)

- Each LCSW and LMFT candidate is to remain registered with her/his licensing board until such time as the candidate is licensed. As stated in the statute, such registration shall be subject to the regulations adopted by the appropriate licensing board.

- The candidate must remain registered even though he/she is no longer accumulating qualifying hours.

The W&IC Section 5751.2 (d): States the requirements of subdivision (a) shall be waived by the department for persons employed or under contract to provide mental health services pursuant to this part as psychologists who are gaining the experience required for licensure. A waiver granted under this subdivision may not exceed five years from the date of employment by or contract with, a local mental health program for persons in the profession of psychology.

- Each psychologist candidate must obtain a waiver - even if he/she is registered with his/her licensing board.

- In order to be eligible for such a waiver, the psychologist candidate must have successfully completed 48 semester/trimester or 72 Quarter units of graduate coursework, not including thesis, internship or dissertation. An official copy of a transcript reflecting completion of this coursework requirement must be submitted with the waiver application.

- There is no statutory provision for extension of psychologist candidate waivers beyond the five year limit.

The W&IC Section 5751.2 (e): States the requirements of subdivision (a) shall be waived by the department for persons who have been recruited for employment from outside the state as psychologists, clinical social workers, or marriage, family, and child counselors whose experience is sufficient to gain admission to the licensing examination. A waiver granted under this subdivision may not exceed three years from the date of employment by or contract with, a local mental health program for persons in these three professions who are recruited from outside the state.

- To be eligible, the psychologist, LCSW, or MFT candidate must be recruited from outside California and have sufficient experience to gain admission to the appropriate

licensing examination. For applicants in this category, a letter from the appropriate California licensing board which states the applicant has sufficient experience to gain admission to the licensing examination must be included with the waiver application.

The following general points should be noted:

- Mental Health Plans (MHPs) should submit and receive approval for waivers under subdivisions 5751.2 (d) [psychologist candidates] and 5751.2 (e) [candidates recruited from outside California whose experience is sufficient to gain admission to the appropriate licensing examination] *prior to allowing candidates to begin work for which a license waiver is required.*

- Waivers are not transferable from one MHP to another. If an individual who obtained a waiver while working for one MHP terminates employment and is subsequently hired by a second MHP, an application for a new waiver must be submitted by the second MHP prior to allowing the candidate to begin work for which a license or waiver is required.

- Once a waiver is granted, the waiver period runs continuously to its expiration point unless the MHP requests that it be terminated earlier.

Use the "Mental Health Professional Licensing Waiver Request" form (and instruction sheet) included in ***(Appendix M – A.M.1).*** Please review the instructions prior to faxing the waiver requests to QI Unit, Attn: Waiver Requests at (619) 563- 2795 or e-mail documents to ian.rosengarten@sdcounty.ca.gov. For additional questions, please contact your QI Specialist.

Documentation and Co-Signature Requirements

Staff that provide mental health services are required to adhere to certain documentation and co-signature requirements. For the most current information on co-signature requirements, please refer to the Documentation and Uniform Clinical Record Manual. This manual will instruct staff on form completion timeframes, licensure and co-signature requirements, and staff qualifications necessary for completion and documentation of certain forms.

Staff Supervision and Management Requirements

- Programs must provide supervision in amount and type that is adequate to insure client safety, maximize gains in functioning, and meet the standards of the professions of those staff employed in the program.

- Programs who employ waivered/registered staff receiving supervision for licensure must offer experience and supervision that meet the requirements of the licensing board to which the person is registered.
- Supervisors may supervise up to 8 clinical staff (licensed, registered, waivered, and trainees) and up to 12 total staff, to include clinical staff.
- Any exceptions to these requirements must be approved by the COTR.
- Contractor shall notify COTR prior to personnel change in the Program Manager position. A written plan for program coverage and personnel transition shall be submitted to CMHS at least 72 hours prior to any personnel change in the Program Manager position. In addition, the resume of candidate for replacement shall be submitted to the COTR for CMHS review and comment at least 72 hours prior to hiring.
- Program shall provide the COTR an organizational chart identifying key personnel and reporting relationships within 72 hours of any changes to organizational structure.

Staffing Requirements

- All providers shall have staff in numbers and training adequate to meet the needs of the program's target population.

- Psychiatry time: Day Treatment programs, including Intensive and Rehabilitation, shall have psychiatry time sufficient to provide psychiatrist participation in treatment reviews, plus one hour per week for medication management per 8 clients on medication (Intensive) or 10 clients on medication (Rehab). Outpatient programs must also have psychiatry time sufficient to allow the psychiatrist's participation in treatment reviews, especially where medications may be discussed, plus up to one hour per month for each new client to be assessed and one half hour per month per client on medications, for medication follow up.

- Head of Service and providing clinical direction: Most programs' contracts require that the Program Manager (Head of Service) be licensed. If the Program Manager is not licensed, there must be a Clinical Lead who can provide clinical supervision and perform certain tasks, such as diagnosing, that are within the scope of practice of licensed and waivered persons.

- Day Treatment staffing: per the requirements of Title 9, the program must maintain a client to staff ratio of 8:1 (for Intensive programs) and 10:1 (for Rehab programs) at all times. Staff counted in the ratio must be Qualified Mental Health Professionals or licensed or waivered. In addition, County guidelines require that at least half the clinical staff in Intensive programs be licensed/waived.
- Outpatient providers' ratio of clinicians/therapists to interns and trainees shall be no more than 1:3 FTE, i.e., there must be at least one FTE licensed clinician per 3 FTE interns and

trainees. Interns and trainees may provide psychotherapy services, under the close supervision of the clinician/therapist.

- Interdisciplinary Team: Programs must have an interdisciplinary team that includes psychiatrists that meet the "psychiatry standards". Psychologists must participate in the regularly scheduled interdisciplinary team meetings where cases are reviewed. A goal of 3-4 hours of licensed psychology time weekly is established for Outpatient programs, a goal of 4 hours for Day Treatment (Intensive) and a goal of 3 hours for Day Treatment (Rehab).
- Any exceptions to these requirements must be approved by the COTR.

Use of Volunteers and Interns/Trainees

- Provider shall utilize family and community members as volunteers in as many aspects of the programming as possible, including teaching a special skill and providing one-on-one assistance to clients. Particular emphasis shall be made to recruit volunteers from diverse communities within program region.
- Provider shall have policies and procedures surrounding both the use of volunteers and the use of employees who are also clients/caregivers.
- Licensed staff shall supervise volunteers, students, interns, mental health clients and unlicensed staff involved in direct client care.
- Interns/trainees assigned to a program must have on file the written agreement between the school and agency with specific time lines which will act to demonstrate the official intern status of the student which determines scope of practice. Copy of document can be maintained in the Signature Log which often stores copies of staff qualifications.

Signature Log and Documentation of Qualifications

- Each program shall maintain a signature log of all individuals who document in the medical record.
- Signature log contains the individual's typed/printed name, credentials/job title and signature.
- Included with the signature log, or in another accessible location, a copy of each individual's qualifications shall be stored (license, registration, waiver, resume, school contract, high school or bachelors degree, documentation of COTR waiver, etc). This documentation is used to verify scope of practice.
- Program is responsible to insure that current copy of qualifications (i.e. license, registration, etc.) is kept on file. Expired documents are to be maintained as they demonstrate qualifications for a given timeframe.
- Signature entries and copies of qualifications of staff that are no longer employed by the program are to be maintained, as they documented in the medical record.

STAFF QUALIFICATIONS AND SUPERVISION

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N. DATA REQUIREMENTS

Data Collection and Retention
All treatment programs shall maintain an outcome data entry system (DES) for all clients. DES entry shall be completed promptly upon collection of data at designated intervals, including intake, UM/UR authorization cycle and discharge.

Outcome Tools and Requirements
Measuring outcomes is an integral aspect of System of Care principles. Standard outcomes have been established for all CMHS treatment providers. Specialized program may have individual program outcomes either in addition to or in lieu of standard outcomes measured by all programs.

- Child/Adolescent Measurement System – Youth (CAMS-Y) – 11years of age or older
- Child/Adolescent Measurement System - Parent/Caregiver (CAMS-P) – all ages
- Child/Adolescent Measurement System -Clinician (CAMS-C) – when acting as caregiver
- Children Functional Assessment Rating Scale (CFARS)– all ages
- Youth Services Survey – Youth (YSS-Y) – 13 years of age or older
- Youth Services Survey – Family (YSS-F) – caregivers of youth up to age 18
- Eyberg Child Behavior Inventory (ECBI) – children 0 through 5 in 0-5 specific programs
- CRAFFT- all ages (as assessment tool only).

Discharge outcomes objective:

- For 80% of discharged clients whose episode lasted 2 months or longer, the CAMS-P total score shall show improvement between intake and the last CAMS collected.
- For 80% of discharged clients whose episode lasted 2 months or longer, the CAMS-Y total score shall show improvement between intake and the last CAMS collected.
- For 80% of discharged clients whose episode lasted 3 weeks or longer, the CFARS score shall be at least one level improved at discharge than at admission in at least one of the four index areas.
- For 80% of those clients, the discharge summary shall reflect no increased impairment resulting from substance use, as measured by the CFARS domain rating for substance use.
- For 80% of discharged clients, the Eyberg scores shall be below the clinical cutpoint on either the ECBI intensity score (132 or below) or the ECBI problem score (15 or below).

Satisfaction outcomes:

- Submission rate of YSS-Y and YSS-F shall meet or exceed the 80% standard established by the County of San Diego Children's Mental Health.

- Aggregated scores on the YSS-Y and the YSS-F shall show an average of 80% or more respondents responding in the two most favorable categories (e.g., 25% Agree plus 55% Strongly Agree) for at least 75% of the individual survey items.

1. Symptoms/Functioning:

Child and Adolescent Measurement System (CAMS)

a) Youth aged 11 and over shall be administered the CAMS modules at intake into the program, UM/UR cycle (session based for outpatient clients and 3 or 6 month UR/Authorization cycle for Day Programs), and at discharge from program.
b) Most current CAMS scores should be considered during UM/UR Authorization supporting medical necessity and clinical effectiveness.
c) Parents/Caregivers of all youth (except those completing the ECBI effective 7-1-10) shall be administered the parent modules of the CAMS on the same cycle. When no guardian is available, staff may be in the role of caregiver (often in a residential program) and complete measure, notating it was completed by clinician/staff.
d) All responses shall be recorded by program staff in the DES, an Access database supplied by CASRC, or as otherwise directed by the County. This database, when utilized, shall permit client results to be compiled for individual cases and by program.
e) Data recorded in the database shall be supplied to CASRC via direct drop off or traceable mailing to ensure HIPAA regulations are followed.
f) Effective June 1, 2010, CAMS data is no longer entered into Anasazi.
g) Medication only cases are excluded from the CAMS measure.
h) Programs exempt from completing the CAMS (such as SES, TBS or DEC) shall maintain written exception documentation from COTR on file.

Children's Functional Assessment Rating Scale (CFARS)

a) All CMHS clients shall be assessed at intake into the program in accordance with the CFARS as part of Behavioral Health Assessment, UM/UR cycle, or the Initial/Annual Client Functioning Form (for TBS & medication only cases). The CFARS shall also be completed annually and at discharge, as part of UM/Authorization forms, the Annual Client Functioning Form (for TBS & medication only cases), Day Program Requests and the Discharge Summary. CFARS scores should be used to support medical necessity and clinical effectiveness.
b) All responses shall be recorded by program staff in the DES, an Access database supplied by CASRC, or as otherwise directed by the County. This database, when utilized, shall permit client results to be compiled for individual cases and by program.
c) Data recorded in the database shall be supplied to CASRC via direct drop off or traceable mailing to ensure HIPAA regulations are followed.
d) CFARS data is entered into Anasazi and embedded in the Day Program Requests and Specialty Mental Health DPRs.
e) Medication only cases are excluded from the CFARS measure.

CRAFFT

a) All CMHS clients shall be assessed for substance use at intake into the program and the CRAFFT shall be administered. The CRAFFT measure is included in the Behavioral Health Assessment in Anasazi.
b) Intake CRAFFT responses shall be recorded by program staff in the DES, an Access database supplied by CASRC, or as otherwise directed by the County. Note that although the CRAFFT must be completed at intake and annually, only the intake responses must be entered into the database. This database, when utilized, shall permit client results to be compiled for individual cases and by program.
c) Data recorded in the database shall be supplied to CASRC via direct drop off or traceable mailing to ensure HIPAA regulations are followed.
d) Medication only cases are excluded from the CRAFFT measure.

Eyberg Child Behavior Inventory (ECBI)

a) Effective 7-1-10 caregivers of children aged 0 through 5 served by early childhood identified programs shall be administered the Eyberg at intake into the program, UM/UR cycle, and at discharge from Contractor's program.
b) The most current Eyberg score shall be considered during UM/Authorization supporting medical necessity and clinical effectiveness.
c) All responses shall be recorded by program staff in the DES, an Access database supplied by CASRC, or as otherwise directed by the County. This database, when utilized, shall permit client results to be compiled for individual cases and by program.
d) Data recorded in the database shall be supplied to CASRC via direct drop off or traceable mailing to ensure HIPAA regulations are followed.
e) Caregivers of children administered the Eyberg shall not be administered the CAMS, but these children require the CFARS, CRAFFT and YSS.
f) Medication only cases are excluded from the Eyberg measure.

2. Client Satisfaction: Currently administered annually to all clients and families who receive services during a selected two-week interval specified by the County MHP (excluding detention programs, medication only cases, inpatient and crisis services). The annual survey will be conducted in May of each year. The survey returns are scanned in to facilitate tabulation, therefore original printed forms provided by the MHP must be used.

Youth Services Survey (YSS)

a) Youth aged 13 and over complete the Youth Services Survey with attached comments page.
b) Parents/caregivers of children and youth up to age 18 complete the Youth Services Survey-Family.
c) Surveys are to be administered in a manner that ensures full confidentiality and as directed by the Child and Adolescent Services Research Center (CASRC).
d) Surveys shall be delivered by hand or through traceable mail adhering to HIPAA regulations to CASRC within 7 days after the completion of each survey interval.
e) Medication only cases are excluded from the YSS measure.

Family Centered Behavior Scale (FCBS) - optional

a) Parent / Guardians of clients may be administered the Family Centered Behavior Scale (FCBS) at each UR / Authorization cycle, and additionally at discharge, along with the other assessment tools.
b) For participating programs, when no measure is obtained (caregiver refuses / not available), enter that information into DES.

Additional outcome objectives:

All providers:

- 100% of all clients shall be assessed for substance use during the assessment period as evidenced by documentation in the medical record and completion of the CRAFFT measure.
- 100% of all clients, ages 16 and older, shall be assessed for transitional service needs as evidenced by documentation in the medical record.
- 100% of all clients shall be assessed for domestic violence issues as evidenced by documentation in the medical record.
- 100% of all clients shall be assessed to determine the need for referral to a primary care physician as evidenced by documentation in the medical record.
- 80% or more of all clients shall receive a minimum of one face- to- face family treatment contact/session per month with the client's biological, surrogate, or extended families, that are able.

Outpatient providers

- 90% of clients will avoid psychiatric hospitalization or re-hospitalization during the outpatient episode.
- Outpatient programs shall maintain an average waiting time of less than 5 days for the client's initial appointment.
- Outpatient programs shall meet or exceed the minimum productivity standard for annual billable time by providing at least 54,000 minutes per year (50% productivity level) for

clinic, school and community based programs per FTE, unless otherwise specified in the program's Statement of Work.

- Case Management services provided by a case manager shall meet or exceed the minimum productivity for annual billable time by providing at least 32,400 minutes per year (30% productivity level) per FTE, unless otherwise specified in the program's Statement of Work.
- Clinical staff shall carry a minimum client load of 30 unduplicated clients per FTE per year for clinic based outpatient programs and 40 unduplicated clients per FTE per year for school and community based outpatient programs, unless otherwise specified in the program's Statement of Work.

Day Treatment providers

- Contractor shall ensure that billable client days shall be produced for 90% of the annual available client days, based upon five (5) days per week or 230-day year.
- 95% of clients will be discharged to a lower level of care unless otherwise specified in the contract.
- 95% of clients will avoid psychiatric hospitalization or re-hospitalization during the Day Treatment episode.

AB2726 Treatment providers

- AB2726 interview timelines shall be adhered to in 100% of referrals.
- Initial intake visit and admission into the program shall be provided within 7 to 14 days of receipt of the referral in 90% of the cases as required by Local AB2726 Interagency agreement. In extenuating circumstances, any exceptions to this standard shall be accompanied by written documentation to the Program Monitor/COTR or their designee.
- Treatment goals shall incorporate AB2726 mental health goals stated in the most current IEP, in 100% of charts.
- Target population shall be students who meet the AB2726 special education criteria for which San Diego Mental Health Services has completed an AB2726 mental health assessment and identified, on an IEP, mental health day treatment as the recommended level of mental health service.
    - Contractor shall ensure and document that eighty percent (80%) of the students' families or surrogate-families participate in weekly family therapy and/or regular alternate activities made available on a regular basis to encourage and maximize family participation in the treatment program and education of the student.
    - Contractor shall ensure that eighty percent (80%) of families be involved in treatment team reviews/meetings each month either by attendance, conference calls, or written input.

Additional Outcome Measures

Additional data may be required in your specific contract. This may involve additional tools for specific parts of the system. Your contract may also require manual collection of certain outcomes from charts, such as number of psychiatric hospitalizations, readmissions, arrests, or changes in level of placement/living situation. The data collected should be submitted on your MSR or as directed by your Program Monitor/COTR.

Research Projects Involving Children's Mental Health Clients

Some providers may develop research projects or test additional outcome tools with methods that utilize MHP clients. All such projects must be reviewed by the MHP's Research Committee as well as the organization's Internal Review Board, if any. Approval is required prior to implementation of the project.

Medi-Cal Administrative Activity Recording (MAA)

Federal and State regulations (Welfare and Institutions Code, Section 14132.47, Medi-Cal Administrative Activities) permit counties to earn federal Medi-Cal reimbursement for activities that are necessary for the proper and efficient administration of a State's Medicaid (Medi-Cal) plan. These MAA activities are focused on assisting individuals to access the Medi-Cal program and the services it covers through such functions as Medi-Cal and mental health outreach, facilitating Medi-Cal eligibility determinations, MAA coordination and claims activities and other designated activities.

Organizational providers may be permitted to provide and claim for MAA activities. The MHP requires that each organizational provider have an approved MAA Claiming Plan prior to claiming MAA activities, and that each provider complies with all applicable State and Federal regulations. MAA activities in mental health are governed by a set of procedures, which are described in detail in the MAA Instruction Manual developed by the State Department of Mental Health.

To assist providers, CMHS offers technical assistance and training on MAA through the MAA Coordinator. The MAA Coordinator can provide assistance with claiming and procedural questions or provide a MAA training to staff.

Included in the attachments to this Handbook is a description of Medi-Cal Administrative Activities Procedures (*Appendix N. N.1*) for providers claiming MAA activities with an approved MAA claiming plan. This handout may be used for reference and training purposes.

Mental Health Service Act (MHSA)

MHSA – Community Services and Support (CSS)

CSS providers are tasked with gathering program specific information as outlined in their contract, and data tracking on the Monthly Status Report (MSR). Additionally, CSS providers administer applicable treatment outcome data and responses are recorded by Contractor's staff in

the DES, an Access database supplied by CASRC, or as otherwise directed by the County. This database permits client results to be compiled for individual cases and by program. Data recorded in the database is supplied to CASRC via direct drop off or traceable mailing to ensure HIPAA regulations are followed.

MHSA - Prevention and Early Intervention (PEI)
PEI providers are tasked with gathering specific demographic data, and a four question general survey which is entered into HOMS. The HOMS database is utilized for gathering the data and managed by the County's Data Centers (HSRC in conjunction with CASRC). Data can be entered directly into the HOMS database or the Data Centers will set up for extracts from contractor's database into the HOMS. Program specific outcome and process data as outlined in contract is captured in the Monthly Status Report (MSR).

MHSA - Innovation
Innovation providers are tasked with gathering specific demographic data, and a general question survey which is entered into HOMS. The HOMS database is utilized for gathering the data and managed by the County's Data Centers (HSRC in conjunction with CASRC). Data can be entered directly into the HOMS database or the Data Centers will set up for extracts from contractor's database into the HOMS. Program specific data as outlined in contract is captured in the Monthly Status Report (MSR).

MHSA Work Force Education and Training (WET)
WET providers are tasked with gathering specific demographic data. The HOMS database is utilized for gathering the data and managed by the County's Data Centers (HSRC in conjunction with CASRC). Data can be entered directly into the HOMS database or the Data Centers will set up for extracts from contractor's database into the HOMS. Program specific data as outlined in contract is captured in the Monthly Status Report (MSR).

MHSA - Full Service Partnerships (FSP)
A number of providers participate in MHSA Full Service Partnerships, which both provide mental health services to clients and link them with a variety of community supports, designed to increase self sufficiency and stability. These providers are required to participate in a State data collection program (DCR) which tracks initial, specialized client assessments, ongoing key incident tracking and quarterly assessments. The State has set timeframes for provisions of each type of data.

O. TRAINING

The increasing focus on cultural sensitivity, outcomes measures, practice guidelines and evidence based practice necessitates the need for ongoing training. Many providers have a contractual obligation to participate in trainings such as:

- Cultural Competency Training – Minimum of four hours annual requirement for all staff. When an in service is conducted, program shall keep on file a sign in sheet for all those in attendance, as well as a training agenda. For outside trainings, certificate of completion shall be kept on file at the program. Contractor shall maintain and submit a Cultural Competence Training Log annually.
- System of Care and Wraparound Training – Every four years all direct service staff must attend. These classes are available through the System of Care Training Academy (619-563-2769) and through Families Forward (619 297-8111). Maintain certificates of completion at provider sites.
- Training in Disaster Response -- as directed by County.
- Contractor shall require clinical staff to meet their licensing Continuing Education Units (CEUs). Other paraprofessional staff shall have a minimum of sixteen (16) hours of clinical training per year.
- Contractor shall require all staff to complete MIS training on Anasazi electronic health record. See below for more detailed information on required trainings. It is recommended that Program Managers attend trainings as well.
- Contractor shall attend trainings as specified in the Behavioral Health Plan.
- Contractor shall schedule with CASRC the training and orientation for DEC.

Electronic Health Record Trainings

Various trainings are available for the electronic health record, Anasazi.

All clerical staff are required to attend Anasazi New Hire Deployment training in order to have access to the system for entering data and pulling reports.

Any staff doing billing for services are required to attend Anasazi Service Entry Training.

Specialized staff are required to attend Anasazi Scheduler training in order to be able to enter staff into the scheduling system and to set appointments for clients.

All clinicians are required to have training in Anasazi in order to complete assessments, client plans, and progress notes. Clinicians will also learn how Scheduler will work for their caseload.

TRAINING

Reports training is available for managers and staff who need to be able to access reports in the Anasazi system.

For information on all Anasazi trainings, please contact the Quality Improvement Unit at 619 584-5026. Managers must submit Anasazi Request Forms (ARF's) and Summary of Policies (SOP) forms to the MIS unit for all new staff prior to registering for trainings.

QI Unit Training

The Quality Improvement Unit provides training and technical assistance on topics related to the provision of services in the Mental Health System of Care. Training covers topics such as Documentation and Uniform Clinical Record Manual Training. For information on training schedules, or regarding any other training issue, please contact the Quality Improvement Unit at 619 584-5026.

P. MENTAL HEALTH SERVICES ACT - MHSA

After California voters passed Proposition 63 in November 2004, the Mental Health Services Act (MHSA), became effective January 1, 2005. The purpose of the act was to expand mental health service funding to create a comprehensive community based mental health system for persons of all ages with serious and persistent mental health problems. The MHP has completed its initial extensive community program planning process and has secured a state approved Community Services and Supports Plan. The next phases of enactment of the MHSA will include funding for prevention/early intervention, innovations, capital facilities and technology, and education and training.

MHSA System Transformation

Under the MHSA, community based services and treatment options in San Diego County are to be improved, expanded, and transformed by:

1. Increasing Client and Family Participation
2. Serving More Clients
3. Improving Outcomes for Clients
4. Decreasing Stigmatization
5. Minimizing Barriers to Services
6. Increasing Planning and Use of Data
7. Increasing Prevention Programming
8. Including Primary Care in the Continuum of Care
9. Using of Proven, Innovative, Values-Driven and Evidence-Based Programs

As a result of expanded funding, the MHSA will hold counties accountable for a number of outcomes. The outcomes include decreases in racial disparities, hospitalizations, incarcerations, out-of-home placements and homelessness while increasing timely access to care. Other outcomes may be required as the State and County evaluate the start-up of MHSA services. Contractors receiving MHSA funding will be responsible for complying with any new MHSA requirements.

MHSA Full Service Partnerships

A number of providers will be participating in MHSA Full Service Partnerships, which both provide mental health services to clients and link them with a variety of community supports, designed to increase self sufficiency and stability. These providers are required to participate in a State data collection program which tracks initial, specialized client assessments, ongoing key incident tracking and quarterly assessments. The State has set timeframes for provisions of each type of data.

MENTAL HEALTH SERVICES ACT - MHSA

For current information on MHSA, visit www.sandiego.networkofcare.org/mh. For current State level and general MHSA information, visit www.dmh.cahwnet/Prop_63.gov/MHSA/default.asp or call (800) 972-6472.

Payment Schedule
Budget Guidelines for Cost Reimbursement Contract Only
(Contractor Instructions)

Q. Payment Schedule Budget Guidelines for Cost Reimbursement

This document includes additional instructions (*in italics*) to help clarify the intent of the requirements and guidelines.
Contractors prepare program budgets for County review and approval. The approved budgets for each fiscal year serve as objectives and guidelines for contract performance and allowable expenditures. The budget guidelines allow for flexibility within specified limits, and states conditions when prior written County approval must be obtained before contractors are allowed to exceed the specified limits for discretionary variance from the approved budget.
The clauses expanded upon below are only those that have been subject to inquiry or that have been recently modified or updated.

Budget Guidelines

Contractor must obtain written approval from the County prior to exceeding any fiscal year's budgeted amounts except as noted in Clauses 0 through □. Unexpended budgeted amounts may not be applied to subsequent fiscal years expenditures unless authorized by an Agreement Amendment. An Agreement Amendment is required prior to exceeding any fiscal year's budgeted maximum Agreement amount.
If expenses are within the allowable limits stated below, no prior approval or change to the budget is required, though all expenses must always be reasonable and appropriate for the contracted services and are subject to subsequent review and approval. Any expenditures requiring written approval must be requested in advance via an Administrative Adjustment or Contract Amendment. Approval is not effective, and contractor should not incur any requested expense, until notified that the Administrative Adjustment or Contract Amendment has been executed.

Total Direct Labor Cost.
Reimbursable direct labor cost for direct labor and program management staff incurred by Contractor in the performance of this Agreement shall be limited to the total amount budgeted for such cost, as evidenced by Schedule I – Agreement Budget, that is attached hereto and by reference made a term and condition hereof. The sum of any and all such expenditures shall not exceed the total amount budgeted for the Salaries and Benefits category plus any allowable unexpended Operating Expenses (as defined in Clause □) without the prior written approval of the Local Mental Health Director or his/her designated representative.
In addition to the stated limitations on the total Salaries and Benefits amount, additional guidelines for changes that require prior written approval are listed below.

Payment Schedule
Budget Guidelines for Cost Reimbursement Contract Only
(Contractor Instructions)

- Unexpended Salaries and Benefits, up to 10% of total budgeted amounts, may be applied to Operating Expenses.

  Example 1: The total Salaries and Benefits amount for a program budget equals $500,000, and contractor expects to spend less than $430,000. Of the $70,000 in projected savings for this category, up to $50,000 (10% of the $500,000 Total Budget), may be applied to Operating Expenses without requiring prior approval or change to the budget.

  Example 2: The total Salaries and Benefits amount for a program budget equals $600,000, and contractor expects to spend less than $570,000. The entire $30,000 in projected savings for this category, which is less than the limit of $60,000, may be applied to Operating Expenses without requiring prior approval or change to the budget.

- Unexpended Salaries and Benefits that may be applied to Operating Expenses may only be from temporary vacancies of budgeted staff.
  Contractor may not purposefully keep positions vacant for the purpose of accruing savings to be applied to Operating Expense. When staffing levels are reduced due to reduced work loads, then it would be expected that operating expenses would be similarly under-expended. The intent is to fill all budgeted positions. Savings due to other reasonable variables can be applied to Operating Expense.
  - Unexpended Salaries and Benefits may be applied directly to any temporary replacement staff and do not require prior approval as long as costs do not exceed amounts budgeted for these positions.
    Temporary and/or replacement staff should be listed in the Salaries and Benefits category, and are not subject to prior approval as long as total of Salaries does not exceed the budgeted amount plus 10% for this category.
  - All staffing changes, including addition or deletion of budgeted staff, and unbudgeted salary increases require prior approval from the County.
    Adequate and appropriate staffing is normally the most important factor in the successful delivery of contracted services. Any permanent change to the number (FTEs) or classification of staff requires prior written approval. Salaries for each classification may be listed as averages, and individual salaries may fluctuate within the range as budgeted, as long as the overall 10% rule is heeded.

Total Other Direct Cost.
Reimbursable operating costs incurred by Contractor in the performance of this Agreement shall be limited to the total amount budgeted for such expenses, as evidenced by Schedule I – Agreement Budget, that is attached hereto and by reference made a term and condition hereof. The sum of any and all such expenditures shall not exceed the total amount budgeted for the Operating Expenses category plus any allowable unexpended Salaries and Benefits (as defined in

Clause 0) without the prior written approval of the Local Mental Health Director or his/her designated representative.

- Unexpended Operating Expenses, up to 10% of total budgeted amounts, may be applied to Salaries and Benefits.
  Example: If the total Operating Expenses for a program budget equals $300,000, any unexpended amount for the year, up to a maximum of $30,000 (10% of the total budget for this category), may be applied to Salaries and Benefits without requiring prior approval or change to the budget.
  - The budgeted amounts for Operating Expenses line items may be exceeded as long as the total of all items does not exceed the total budgeted Operating Expenses (including any allowable unexpended Salaries and Benefits as defined in Clause 0), except for Leasehold Improvements, Consultants, Interest Expense, and Depreciation.
    Example: If $1,000 is budgeted for Office Supplies and the expenses to date equals $1,500, no prior approval or change to the budget is needed unless the total Operating Expenses amount is exceeded beyond allowable limits; however, all expenses must be reasonable and appropriate for the contracted services and are subject to subsequent review and approval.
  - Consulting expenses are budgeted on Schedule II of the Agreement Budget and may not be exceeded without prior approval, with the exception of temporary staffing as per Clause □. All other consulting services not previously budgeted require prior written County approval.
  - Budgeted amounts for Leasehold Improvements, Interest Expense, and Depreciation may not be exceeded without prior written County approval.
  - No expense will be allowed for any line item that does not have an amount currently budgeted.
    Any expense within a line item that has no currently budgeted amount requires prior approval. It is assumed that the approved budget includes most expected expenditures, and unbudgeted items were deliberately omitted; therefore, prior approval is required if an unbudgeted expense is subsequently considered necessary.

Fixed Assets.
All fixed asset expenses must be budgeted and itemized on Schedule II, and no line item budget may be exceeded without prior written County approval. Purchase of fixed assets not currently budgeted and itemized requires prior written County approval. Fixed assets include all non-expendable property with a value of $5,000 or more and a normal life expectancy of more than one year.
Purchase of fixed assets that are budgeted on the itemized Schedule ll and any assets not currently budgeted require written notification to the COTR.

Payment Schedule
Budget Guidelines for Cost Reimbursement Contract Only
(Contractor Instructions)

Total Indirect Cost.
Reimbursable indirect costs incurred by Contractor in the performance of this Agreement shall be limited to the total amount budgeted for such cost, as evidenced by Schedule III – Indirect Cost Statement, attached hereto and by reference made a term and condition hereof. The sum of any and all such costs shall not exceed the total amount budgeted for the Indirect Cost category without the written approval of the Local Mental Health Director or his/her designated representative. Reimbursable indirect costs shall be limited such that the ratio of actual total Indirect Cost to actual total Gross Cost shall not exceed the ratio of budgeted Indirect Cost to budgeted Gross Cost.
If the total budget is under-expended, it is expected that Indirect Costs would decrease proportionately.

- Budgeted Units of Service may not be changed without prior written County approval.

Units of Service are the most critical element of the program budget and the budgeted units of service may not be changed without prior written approval. Delivery of service below budgeted levels may be a performance issue and subject to notice of required corrective action.

R. QUICK REFERENCE

PHONE DIRECTORY

Access And Crisis Line	**1-800-479-3339**
County Of San Diego MHP Administration	**619-563-2700**
Children's Mental Health Administration	619-563-2750
Chief, TBS and Outpatient Services	619-563-2773
Chief, Juvenile Forensic Services	858-694-4695
Chief, Critical Care and Outpatient Services	619-421-6900
Chief, Special Education Services	619-758-6226
Director, Quality Improvement Unit	619-563-2754
Quality Improvement Program Manager	619-563-2747
Quality Improvement FAX	619-236-1953
QIMatters.hhsa@sdcounty.ca.gov	
Contract Administration Unit Manager	619-563-2733
Claim Submission FAX	619-563-2730
Mental Health Billing Unit	619-338-2612
FAX	858-467-9682
Email	mhbillingunit.hhsa@sdcounty.ca.gov
Administrative Services Organization for San Diego MHP	
Optum Health, San Diego Provider Line	**800-798-2254**
Optum Health Administrative Services for MHP	**619-641-6800**
Director, Compliance and Provider Services	619-641-6806
Anasazi Assistance - Optum Help Desk	800-834-3792
Client Advocacy Organizations	
Consumer Center for Health Education and Advocacy (CCHEA)	877-734-3258
JFS Patient Advocacy Program	800-479-2233
Deaf Community Services	**800-290-6098**
Interpreters Unlimited	**858-451-7490**
World Wide Web Resources	
County of San Diego	www.sdcounty.ca.gov
Optum Health	www.optumhealthsandiego.com
California Board of Behavioral Sciences	www.bbs.ca.gov

QUICK REFERENCE

California Board of Psychology	www.psychboard.ca.gov
California Code of Regulations	www.calregs.com
California Department of Mental Health	www.dmh.ca.gov
California Medi-Cal Website	www.medi-cal.ca.gov
California Mental Health Directors Association	www.cmhda.org
California Welfare & Institutions Code	www.leginfo.ca.gov/calaw.html
Center for Medicare and Medicaid Services	www.cms.hhs.gov
Community Health Improvement Partners	www.sdchip.org
Disability Benefits 101	www.disabilitybenefits101.org
Inform San Diego (Social Services Database)	www.informsandiego.com
211 San Diego (Social Services Database)	www.211sandiego.org
Intentional Care Website	www.intentionalcare.org
International Association of Psychosocial Rehabilitation Services (IAPSRS)	www.iapsrs.org
Joint Commission on Accreditation of Healthcare Organizations	www.jcaho.org
National Institute of Mental Health (NIMH)	www.nimh.nih.gov
Network of Care	www.networkofcare.org
Office of Inspector General Exclusion List	www.oig.hhs.gov
GSA Excluded Parties Listing System (debarment)	http://epls.arnet.gov
Social Security Online	www.socialsecurity.gov or www.ssa.gov
Ticket to Work Program	www.yourtickettowork.com